ADHS/CRSA

Operational and Financial Review
Contract Year Ending 2007

March 12 through 16, 2007

Conducted by the Arizona Health Care Cost Containment System

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INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) has served Arizona's most needy since 1982. The Agency's vision is "to shape tomorrow's managed care system with today's experience, quality and innovation." As a component of achieving this vision, AHCCCS regularly reviews contracted Contractors to ensure that their operations, finances and performance are in compliance with Federal and State law, rules and regulations, and the AHCCCS contract. The reviewers use a process approved by the Centers for Medicare and Medicaid Services (CMS) based upon the terms of its contract with AHCCCS.

The primary objectives of ADHS/CRSA CYE07 Operational and Financial Review are to:

- Determine if the Contractor satisfactorily meets AHCCCS' requirements as specified in the Contract Year Ending 2007 (CYE 07) contract, AHCCCS policies and the Arizona Administrative Code (AAC).
- Increase AHCCCSA knowledge of the Contractor's operational and financial procedures.
- Provide technical assistance and identify areas where improvements can be made as well as identifying areas of noteworthy performance and accomplishments.
- Review progress in implementing recommendations made during prior Operational and Financial Reviews.
- Determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.
- Perform Contractor oversight as required by the Centers for Medicare and Medicaid Services in accordance with AHCCCS' 1115 waiver.
- Provide information to an External Quality Review Organization (EQRO) for its use as described in CFR 438.364.

The CYE 07 Review Team included employees of the Division of Health Care Management (DHCM) in: Acute Care Operations, Reinsurance, Data Analysis and Research (DA&R), Medical Management (MM), Clinical Quality Management (CQM), the Office of Administrative Legal Services (OALS), and the Division of Business and Finance – Third Party Liability (TPL),

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ADHS/CRSA serves eligible enrolled members throughout the state. ADHS/CRSA has contracted with the AHCCCS since 2002.

The standards used by the reviewers are provided to the Contractor approximately two weeks prior to the onsite review. The Review Team performed an extensive document review, conducted interviews with appropriate Contractor personnel and observed the staff at work. Unless otherwise noted the Contractor had the appropriate written policies for each of the areas reviewed. A brief summary and performance assessment of each program area follows:

Delegated Agreements

The Contractor has made significant progress since the last OFR in developing oversight mechanisms to monitor the performance of its delegated entities. Historically, the Contractor has not demonstrated consistent follow up in validation of the implementation of corrective actions when deficiencies are identified with at the Regional Contractor level. The Contractor started quarterly site reviews in November and has submitted the Annual Administrative Tool to AHCCCS for approval. The Contractor had not begun the annual reviews of its Regional Contractors at the time of this review. The Contractors current contracts will be extended to contract year 7/1/07 through 6/30/08.

Delivery Systems

The Contractor has updated its policies to support all standards in this area. However, the Contractor should expand and improve its documentation of oversight activities. Furthermore, the Contractor should improve the monitoring and execution of Subcontractor corrective action plans to ensure compliance with AHCCCS standards, particularly in the area of appointment standards.

General Administration and Corporate Compliance

The Contractor is currently under corrective action from AHCCCS for the development of uniform policies and procedures for the training of employees and subcontracted clinics as well as streamlining operations and reporting mechanisms. As a result of this review, it has been determined that the Contractor has made significant progress on these requirements but implementation is not complete. Reporting mechanisms between the clinics and the CRSA should be strengthened to ensure the accuracy of submitted data. This will require the Contractor to dictate methodology and perform more frequent auditing. The Contractor has made it clear that Compliance training and

auditing will be performed in conjunction with the administrative review process that CRSA has implemented for review of the contractual compliance of subcontracted clinics.

Grievance Systems

The Contractor has completed training of all the Regional Clinic sites regarding the standards and requirements of the Notice of Action letter, decision timeliness and letter requirements but are not in full compliance with the standards of the letter. CRSA remains on a 100% review of the Notice of Action Letters, including their oversight and monitoring of the Regional Clinics. The Contractor has updated policies for the appeal and claim dispute processes. Grievance System training has been provided for the regional contractors. The appeal and claim disputes are being timely adjudicated. The Contractor must continue training to ensure that all appeal and claim dispute process requirements are completed and documented.

Medical Management

The Contractor demonstrated obtaining utilization and provider profiling data within the last two quarters. The Contractor has not had adequate time to evaluate any recently instituted interventions that have resulted from recent data analysis. The Contractor must implement and monitor all staff involved in inter-rater reliability to ensure consistency among staff when applying standardized criteria in making clinical determinations. The Contractor must develop a policy and process for review and payment of emergency services.

Quality Management

The Contractor has made significant progress during the past year as part of the Notice to Cure process in developing a stable quality management program structure to ensure quality of care concerns from throughout the system are referred to Quality Management for investigation. However, several critical quality program functions such as Peer Review, annual audits of Regional Contractors, monitoring of the Regional Contractor's Corrective Action Plans and interventions and credentialing of Regional Contractors have not yet been implemented by the Contractor. Implementation of these processes will be necessary for the Contractor to become compliant with all AHCCCS requirements. The Contractor's lack of a health information system that allows for tracking, trending and analyzing accurate data is also a major area of concern. Currently, the Contractor is not meeting the minimum performance standard for any of the three contractual performance measures. The Contractor has identified problems with internal data collection for these measures, and working to resolve them. The Contractor has made progress in conducting Performance Improvement Projects.

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Recipient Services

The Contractor has delegated recipient notifications and services to its Regional Contractors. However, the Contractor should continue to improve its process for overseeing, recording and analyzing subcontractor compliance. The Contractor should also continue to improve its monitoring and oversight of the education and training of subcontractor staff to ensure compliance with Recipient Services standards in a formal manner.

Claims Systems

The Contractor has created an internal Administration-level position that will be responsible for overseeing the individual clinic claim processing compliance. Review results have shown that a lack of uniform reporting and training mechanisms has contributed to a lack of understanding at the Administration level of the inner workings of its individually contracted claims processing units. It is difficult at this time to comment on the effectiveness and/or adequacy of the planned interventions due to the fact that they have not been tested, however, interview responses demonstrate an understanding of the shortcomings of the current system.

Cultural Competency/Limited English Proficiency

The Contractor has developed a comprehensive Cultural Competency Program which understands and accommodates the cultural challenges faced by CRS recipients. The Contractor has developed and utilizes a parent's council which participates in the creation of recipient materials which provides a unique and highly beneficial component to the program. This is considered a best practice among current the AHCCCS Contractors. The Contractor should continue to implement its program by ensuring staff members and subcontractor's staff receive training on the culture of being a child with a CRS health condition, that they are proficient in interpretation and translation services, and that each Subcontractor corrects deficiencies when identified.

Encounter Systems

Overall the Contractor has systems in place to submit complete, accurate and timely encounter data; and to track and audit adjudicated, denied, deleted and pended encounters. Review findings indicate the ratio of professional encounter services is lower than expected. The Contractor needs to review its system processes to verify complete encounter systems. AHCCCSA is currently implementing system upgrades to aid contractors in data submission and approval.

AHCCCSA has also scheduled one-on-one meetings to provide additional tailored technical assistance to meet contractor specific needs.

Third Party Liability
The Contractor has policies and procedures in place to oversee the COB activities, and post payment recoveries, of their contracted plans.

The Contractor's initial draft of this report was sent on **May 18, 2007**

There has been ongoing monitoring of the Contractor's corrective action plans from the CYE 06 review. The Contractor is up to date with the steps listed in their corrective action plans. AHCCCS will add the corrective action plans from this review to the monitoring process.

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FINDINGS

Rating Definitions

Standards are usually rated based upon the percentage of the findings that meet the standard. When a different methodology is used it is noted in the standard. The ranges are defined below.

Full Compliance: The Contractor is 90-100% in compliance with the standard or sub-standard findings.

Substantial Compliance: The Contractor is 75-89% in compliance with the standard or sub-standard findings.

Partial Compliance: The Contractor is 50-74% in compliance with the standard or sub-standard findings.

Non-Compliance: The Contractor is 0-49% in compliance with the standard or sub-standard findings.

Not Applicable: This standard does not apply to the Contractor and/or the standard/sub-standard is not a contractual requirement and/or there have been no instances in which the requirement applied.

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Recommendation Definitions

The Contractor must..... This indicates a critical non-compliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.

The Contractor should..... This indicates a non-compliance area that must be corrected to be in compliance with the AHCCCS contract, but it is not critical to the everyday operation of the Contractor.

The Contractor should consider..... This is a suggestion by the Review Team to improve operations of the Contractor, although it is not directly related to contract compliance.

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CLAIMS SYSTEMS

STANDARDS	FINDINGS	RECOMMENDATIONS
CS1	NA	Reserved
CS2	NA	Reserved
CS3	SC	The Contractor should develop a mechanism for informing non-contracted physicians/specialists of the appropriate addresses for claim submission.
CS4	PC	The Contractor should develop a uniform policy and procedure for the Subcontractors' generation of remittance advices that contains all contractually required elements.
CS5	PC	The Contractor must develop mechanisms for the auditing of claim processing that allow for correction of systemic errors and identification of appropriate provider-level educational interventions. The Contractor must develop internal policies and procedures to ensure the validity of COB information gathered from recipients to minimize the necessity for post-payment recouping.
CS6	FC	The Contractor should ensure that site-specific recovery policies are in place at each subcontracted clinic.
CS7	FC	The Contractor should ensure that site-specific recovery policies are in place at each subcontracted clinic.
CS8	NC	The Contractor must implement a mechanism for the uniform reporting and validation of claim dispute information in order to track, trend, report and develop interventions in a consolidated manner.
CS9	NC	The Contractor must develop a procedure for the review of, and response to, data gathered from the newly developed centralized repository for Claim Dispute and Appeal information that includes appropriate interventions.
CS10	NC	The Contractor must ensure that interest penalties are applied to all institutional claims paid after 60 days of receipt.
CS11	NC	The Contractor must ensure that the subcontracted clinics are capable of accepting electronic claims and that they are sufficiently promoting the utilization of this process.
CS12	PC	The Contractor must ensure that the subcontracted clinics are able to audit claim accuracy and that

		reporting is uniform and accurate.
CS13	NC	The Contractor must ensure that individual claim processors are subject to accuracy audits.
CS14	FC	The Contractor should consider implementation of the requirement to stratify claims in inventory by category of paid; denied; pended for inconsistency and pended for medical review.
CS15	FC	The Contractor should consider developing a “roll-up” of the submitted data for trending purposes.
CS16	FC	None
CS17	PC	The Contractor should ensure that all clinics meet the contractual standards for claim processing rates.
CS18	NC	The Contractor must ensure that appropriate encounter transactions are submitted by the subcontracted clinics in order that timely and accurate encounter data is forwarded to AHCCCS.
CS19	SC	The Contractor must require all subcontracted clinics to maintain policies and procedures that ensure the reprocessing of overturned claim disputes in a timely manner.
CS20	SC	The Contractor should ensure that a record of the date of payment is maintained with the claim dispute file and in any data warehousing application.
CS21	SC	The Contractor should ensure that all subcontractor claims processing personnel are adequately trained on the processing of CRS related claims for payment and that periodic update occurs.

FC = Full Compliance SC = Substantial Compliance PC = Partial Compliance NC = Non-Compliance NA = Not Applicable

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CULTURAL COMPETENCY/LIMITED ENGLISH PROFICIENCY

STANDARDS	FINDINGS	RECOMMENDATIONS
CUC/LEP1	FC	None
CUC/LEP2	PC	The Contractor/Subcontractors must have policies or processes on Cultural Competency Trainings. The Contractor/Subcontractors must have processes to ensure qualifications of multilingual staff.
CUC/LEP3	NC	The Contractor must provide a cultural competency orientation for its employees. The Contractor must provide ongoing training and evaluations of Contractor staff providing culturally and linguistically appropriate services to members. The Contractor must develop a methodology to assess the cultural competency of its employees. The Contractor must modify training content based on deficiencies noted in the assessments.
CUC/LEP4	PC	The Contractor must have a provider-training schedule for the audit period. The Contractor must have evidence of provider orientation and/or training materials that provide education on cultural and linguistic contractual requirements. The Contract should consider standardizing the Cultural Competency Training for the providers at the Subcontractor level.
CUC/LEP5	NC	The Contractor must use communication methods, other than the member handbook, to notify members that information and materials are available in other formats and languages.
CUC/LEP6	SC	The Contractor should identify all prevalent languages spoken by its membership.
CUC/LEP7	FC	None
CUC/LEP8	NC	The Contractor must document on the results of language proficiency assessments of Contractor staff. The Contractor must provide evidence of qualifications for all staff that are utilized to provide interpretation services to members (e.g., certificates, testing scores, qualifications of vendors, etc.).

CUC/LEP9	FC	The Contractor should gather data on and analyzed the interpretation services requested by their recipients to ensure adequate access for members.
CUC/LEP10	PC	The Contractor must provide evidence that the staff has worked to correct provider office deficiencies discovered through oversight efforts.

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DELIVERY SYSTEMS

STANDARDS	FINDINGS	RECOMMENDATIONS
DS1	FC	None
DS2	NA	Reserved
DS3	NC	The Contractor must improve its oversight of its Subcontractors to ensure the AHCCCS standard for clinic appointment availability within 45 days of referral is met. The Contractor should consider developing a reporting methodology that monitors the number of days from referral that routine specialty care appointments are available, per clinic.
DS4	NA	Reserved
DS5	NA	Reserved
DS6	FC	The Contractor should consider increasing the frequency of the telephonic survey and/or conducting periodic on-site visits to randomly assess actual office wait times.
DS7	NC	The Contractor must employ a corrective action process that results in Subcontractor and/or provider compliance with AHCCCCS appointment standards. This must include a process for identifying the root cause of the problem, monitoring the execution of the corrective action plan, and taking definitive action to remedy continued non-compliance.
DS8	NA	Reserved
DS9	NA	Reserved
DS10	NA	Reserved
DS11	NA	Reserved
DS12	NC	The Contractor must develop a policy and process for ensuring that Provider Services Representatives

		are adequately trained. The process must include an orientation and on-going training for Provider Services Representations. In the event the Contractor continues to delegate the provider services function to Subcontractors, the Contractor must maintain sufficient oversight of and coordination with Subcontractors to ensure that Provider Services Representatives are adequately trained.
DS13	NA	Reserved
DS14	NA	Reserved
DS15	FC	None
DS16	FC	None
DS17	NA	Reserved
DS18	FC	None
DS19	SC	The Contractor should ensure contracted providers receive provider education materials on an ongoing basis.
DS20	FC	None
DS21	FC	None
DS22	FC	None
DS23	NC	The Contractor must develop a procedure for documenting and ensuring that consultation reports are sent to the referring physician and Acute/ALTCS Contractor within 30 days of the first CRS clinic visit.
DS24	NC	The Contractor must develop and submit a monthly recipient specific clinic report to the Acute/ALTCS Contractor's Medical Director in compliance with the standard.
DS25	FC	None
DS26	NC	Contractor must ensure that the initial medical evaluation is scheduled within 30 days of the preliminary medical determination.
DS27	FC	None
DS28	FC	None
DS29	FC	None
DS30	NA	Reserved

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ENCOUNTERS

STANDARDS	FINDINGS	RECOMMENDATIONS
ENC1	SC	The Contractor should continue its efforts to ensure all encounters are submitted completely, timely and accurately. Contractor must review its system processes to validate that all CRS paid claims are encountered to AHCCCS.
ENC2	FC	None
ENC3	FC	None
ENC4	FC	None
ENC5	NA	None
ENC6	PC	The Contractor should continue its efforts to ensure all encounters are submitted completely, timely and accurately. Contractor must review its system processes to validate that all CRS paid claims are encountered to AHCCCS.
ENC7	FC	None
ENC8	FC	None
ENC9	FC	None
ENC10	FC	None
ENC11	FC	None
ENC12	FC	None

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GENERAL ADMINISTRATION (INCLUDES CORPORATE COMPLIANCE)

STANDARDS	FINDINGS	RECOMMENDATIONS
GA1	FC	None
GA2	N/A	Reserved
GA3	NC	The Contractor must create policies and procedures regarding the timely loading of physician contracts and fee schedules.
GA4	PC	The Contractor must implement and enforce uniform auditing policy to ensure claim payment systems are correctly populated.
GA5	PC	The Contractor should finalize and implement a standardized New Employee Orientation for all employees at the Administration and Clinic level.
GA6	FC	None
GA7	FC	None
GA8	FC	None
GA9	FC	The Contractor should consider adding a frequency table to its policy on policy development.
GA10	SC	Tucson website should include the formulary, policies and procedures, recipient handbook and provider listings.
CC1	FC	None
CC2	FC	None
CC3	FC	None
CC4	SC	The Contractor should include Compliance training in the final standardized orientation program and require annual refreshing for all employees to ensure full agency training within one calendar year.
CC5	FC	None
CC6	FC	None
CC7	FC	None
CC8	SC	The Contractor employee training materials should include language that all employees have direct access to a confidential compliance reporting mechanism.
CC9	NC	The Compliance Officer must review of fraud and abuse cases for appropriate referral to Office of Program Integrity (OPI).

CC10	FC	None
CC11	NC	The Contractor must review the effectiveness of the compliance program and timeliness of compliance reporting within the current contract year.
CC12	FC	None

FC = Full Compliance SC = Substantial Compliance PC = Partial Compliance NC = Non-Compliance NA = Not Applicable

AUTHORIZATION AND DENIAL/GRIEVANCE SYSTEM

STANDARDS	FINDINGS	RECOMMENDATIONS
GS1	SC	The Contractor should continue with regional site reviews and audit all service request denials on a bi-monthly submission from the providers. The Contractor should develop a process to assure all denials are signed by a Medical Director.
GS2	SC	The Contractor must continue with regional site reviews and audit all service request denials on a bi-monthly submission from the providers. The Contractor should provide oversight tools and corrective action plans for all regional clinics on a bi-monthly submission.
GS3	SC	The Contractor must continue with regional site reviews and audit all service request denials on a bi-monthly submission from the providers. The Contractor should provide oversight tools and corrective action plans for all regional clinics on a bi-monthly submission.
GS4	PC	The Contractor must develop a process for monitoring timeliness of prior authorization to include point of entry to ensure decision timeframes.
GS5	PC	The Contractor must revise the template use easily understandable language. The completed template should be forwarded to AHCCCS for final approval. The Contractor should develop a process for monitoring of notice of extension timelines in approved service authorization requests. It is recommended that the Contractor send 100% of Notice of Extension letters to AHCCCS on a bi-monthly basis.
GS6	PC	The Contractor must develop process for monitoring timelines for prior authorization requests.
GS7	FC	None

GS8	FC	None
GS9	SC	The CRSA must ensure that all claim disputes are acknowledged within 5 days of receipt.
GS10	FC	None
GS11	FC	None
GS12	FC	None
GS13	FC	None
GS14	NA	NA
GS15	NC	CRSA must ensure that all claim dispute Notice of Decision indicate the factual and legal basis for the decision.
GS16	FC	None
GS17	FC	None
GS18	FC	None
GS19	SC	The CRSA must ensure that their Contractor documents any authorization or provision of service that is the result of an overturned denial.
GS20	FC	None
GS21	FC	None

FC = Full Compliance SC = Substantial Compliance PC = Partial Compliance NC = Non-Compliance NA = Not Applicable

MEDICAL MANAGEMENT

STANDARDS	FINDINGS	RECOMMENDATIONS
MM1	SC	The Contractor must evaluate the interventions planned as a result of trended data analysis.
MM2	SC	The Contractor must evaluate the interventions planned as a result of trended data analysis.
MM3	FC	None
MM4	NA	None

MM5	NC	The Contractor must implement and monitor all staff involved in the clinical review process to assure consistent application of the criteria used for decision making. The Contractor must assure the inter-rater reliability monitoring is comprehensive for all covered services that are included in prior authorization, concurrent and retrospective review.
MM6	FC	None
MM7	PC	The Contractor must have a process for trending and analysis of their retrospective reviews.
MM8	FC	None
MM9	SC	The Contractor should consider reporting in the Executive Management Committee any new medical technologies that were requested and the timeframes for decision so that any trends can be identified.
MM10	NA	None

FC = Full Compliance SC = Substantial Compliance PC = Partial Compliance NC = Non-Compliance NA = Not Applicable

RECIPIENT SERVICES

STANDARDS	FINDINGS	RECOMMENDATIONS
RS1	FC	None
RS2	FC	None
RS3	NA	Reserved
RS4	SC	The Contractor must ensure that the New Recipient Orientation Packet includes the current Recipient Handbook.
RS5	FC	None
RS6	NA	Reserved
RS7	NA	Reserved
RS8	NC	The Contractor must develop a process and policy for training staff to ensure that the recipient's dignity and privacy are protected and the recipient is treated with respect.
RS9	SC	The Contractor should develop a process to ensure Contractor and Subcontractor staffs are monitored on a regular and periodic basis.

RS10	FC	None
RS11	FC	The Contractor should consider developing a formal process for tracking the referral of recipient inquires and grievances to other units/departments as appropriate.
RS12	FC	None
RS13	FYI	None
RS14	FC	None
RS15	FC	None
RS16	FYI	None
RS17	NC	The Contractor must ensure that AHCCCS DHCM is notified of a material change in the provider network 15 days prior to the provider notice being sent out.

FC = Full Compliance SC = Substantial Compliance PC = Partial Compliance NC = Non-Compliance NA = Not Applicable

DELEGATED AGREEMENTS

STANDARDS	FINDINGS	RECOMMENDATIONS
DA1	NA	None
DA2	FC	None
DA3	FC	None
DA4	FC	None
DA5	NC	The Contractor must evaluate and monitor the delegated entities performance on a regular basis and subject the delegated entity to a formal review according to a periodic schedule.
DA6	NC	The Contractor must show evidence that it requires corrective action from a delegated entity when areas of deficiency or improvement are identified.
DA7	FC	None

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QUALITY MANAGEMENT

STANDARDS	FINDINGS	RECOMMENDATIONS
QM1	FC	None
QM2	SC	The Contractor must document implementation of a formal Peer Review process to be in compliance with AHCCCS requirements. The Contractor must clearly state in the Contractor Peer Review Policy that the Contractor Medical Director or his designated ADHS Medical Director will chair the Quality Management Committee and Peer Review Committee.
QM3	SC	The Contractor must report issues to the appropriate agencies and regulatory bodies as stated in the AMPM, Chapter 900, Policy 960. The Contractor must develop a process to identify all quality of care concerns from all potential sources. The Contractor should consider standardizing QOC file structure to ensure completeness and accuracy. The Contractor should consider utilizing the QOC Documentation-Data File monitoring tool to review the Contractor cases. The Contractor should develop a process for standardizing the QOC file structure including: dating and initialing entries made to the database; signing the database when the case is closed; checking the database entries to ensure that the case disposition and follow-up match; filling in the date that requested information was received and indicating if mail was returned by the post office. The Contractor should consider entering the main and sub-allegations; provider and sub-provider into the database at the time the case is opened to assist with trending reports. There was no evidence that the Contractor has implemented a process to communicate concerns with appropriate agencies.
QM4	SC	The Contractor must monitor the success of the interventions developed as a result of member complaints to be in compliance with AHCCCS requirements. The Contractor should consider an

		ongoing process, rather than relying solely on the Annual Administrative Review audit to evaluate the success of interventions.
QM5	NC	The Contractor must continue to identify barriers and solutions to improving rates for contractual performance measures, in order to meet the AHCCCS Minimum Performance Standards. Any deviations in data collection methodology, such as adding exclusion criteria, must be approved by AHCCCS and incorporated into the Contractor contract prior to implementation.
QM6	FC	None
QM7	PC	The Contractor must validate that Regional Contractors are licensed to operate in the State. The Contractor must verify that organizational providers are compliant with other applicable State or Federal requirements.
QM8	SC	A delegated entity must be monitored on an ongoing basis and formally reviewed by the Contractor at least annually to be in compliance with AHCCCS requirements. The Contractor must ensure that the Regional Contractors accept and implement the Contractor's required corrective action if any deficiencies are identified.
QM9	FC	None
QM10	SC	The Contractor must ensure policies are approved and signed by the Contractor Medical Director (representing governing or policy-making body) as well as Executive Management.
QM11	PC	The Contractor must include all requirements of the AHCCCS AMPM Chapter 900, Policy 950 relating to the initial credentialing, re-credentialing and provisional credentialing of providers by Regional Contractors to be in compliance with AHCCCS requirements.
QM12	FC	None
QM13	PC	The Contractor must develop a health information system to collect, integrate and analyze data. The health information system data must be validated for accuracy, timeliness, logic and completeness.
QM14	NC	The Contractor must ensure all Regional Contractors have a health information data system. The Contractor must develop a process for integrating, analyzing and evaluating data from all Regional Contractors in order to develop accurate and appropriate quality improvement activities.

QM15	FC	None
QM16	FC	None
QM17	FC	None
QM18	FC	None
QM19	FC	None

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THIRD PARTY LIABILITY

STANDARDS	FINDINGS	RECOMMENDATIONS
TPL1	FC	None
TPL2	FC	None
TPL3	FC	None
TPL4	FC	None
TPL5	FC	None
TPL6 - TPL 9	NA	Reserved
TPL10	FC	None
TPL11	FC	None
TPL12	FC	None

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Claim Systems

AHCCCS REVIEW TEAM:	Rodd Mas, Manager, Acute Care Operations David Bjorn, Operations & Compliance Officer Gina Aker, Operations & Compliance Officer Maureen Wade, Manager, Medical Manager
CONTRACTOR STAFF:	Margery Sheridan, Chief, Consumer Rights Cynthia Layne, Chief Financial Officer Jerri Gray, HIPAA Data Manager
DATE OF REVIEW:	**March 12 through March 16, 2007**

Claim Systems

Standard
CS 1
Reserved

Claim Systems

Standard
CS 2
Reserved

Claim Systems

Standard
CS 3
The Contractor has a mechanism in place to inform providers of the appropriate place to send claims.
[Contract Section D, Paragraph 25, Attachment F; 42 CFR 438.242]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor ensures that its Subcontractor has a mechanism in place to inform contracted providers of the appropriate place to send claims.

Documents Reviewed:
Provider Manuals

Comments:
Contractor and subcontractors have included the address for claim submission in each respective provider manual. However, the Contractor did not provide evidence of a mechanism for informing non-contracted physicians/specialists of the appropriate billing addresses.

Recommendations:
The Contractor should develop a mechanism for informing non-contracted physicians/specialists of the appropriate addresses for claim submission.

Claim Systems

Standard
CS 4
The Contractor's remittance advice to providers must contain, at a minimum, adequate descriptions of all denials and adjustments, the reasons for such denials and adjustments, the amount billed, the amount paid, application of Coordination of Benefits, and provider rights for claim dispute.
[Contract Section D, Paragraph 25; Attachment F]

Findings: PARTIAL COMPLIANCE
The Contractor does not ensure that each of its Subcontractors' remittance advices to providers contain an adequate description of all denials and adjustments.

The Contractor does not ensure that each of its Subcontractors' remittance advices to providers contain the reasons for denials and adjustments.

The Contractor ensures that its Subcontractor's remittance advice to providers contains the amount billed.

The Contractor ensures that its Subcontractor's remittance advice to providers contains the amount paid.

The Contractor ensures that its Subcontractor's remittance advice to providers contains application of Coordination of Benefits.

The Contractor does not ensure that each of its Subcontractors' remittance advices to providers contain provider rights for claim dispute.

Documents Reviewed:
Remittance advice from each of four Subcontractors
Supplemental Claim Dispute Information for Phoenix, Flagstaff and Yuma Clinics

Claim Systems

Comments:
The Tucson and Yuma clinic remittance advices did not contain adequate descriptions and reasoning of denials and adjustments. Additionally, the Tucson clinic remittance advice did not contain information on how Coordination of Benefits was applied to the final payment amount or the Providers' rights for claim dispute under Arizona Administrative Code R9-34-401 et seq.

It was stated during the interview process, and in documentation, that the Tucson clinic informs providers of claim dispute rights through the provider manual and in site visits. However, the contractual requirement is that each remittance advice contains this information. Narrative response from the Contractor (CRSA) stated that application of Coordination of Benefits was not a specified requirement for remittance advices under the applicable contract clause. This is a misunderstanding of the requirement to provide adequate description of how payment was determined.

Recommendations:
The Contractor should develop a uniform policy and procedure for the Subcontractors' generation of remittance advices that contains all contractually required elements.

Claim Systems

Standard
CS 5
The Contractor has a methodology to identify and timely recoup erroneously paid claims. The Contractor has a process to identify claims which the Contractor is a secondary payor, prior to payment to minimize the need for recoupment. [Contract Section D, Paragraph 25, Attachment; F; 42 CFR 438.242(a)]

Findings: PARTIAL COMPLIANCE
The Contractor does not sufficiently ensure that its Subcontractors have a methodology to identify erroneously claims prior to payment to minimize the need for recoupment.

The Contractor does not sufficiently ensure that its Subcontractors have a methodology to identify erroneously paid claims to minimize the need for recoupment.

Documents Reviewed:
Over/Underpayment logs for Flagstaff, Phoenix and Yuma Clinics
CRSA Policy FM 1.5 – Claim Over and Under Payment Monitoring and Oversight
Tucson, Phoenix and Yuma Coordination of Benefits Policies
RCPPM 50.200
RCPPM 50.301
RCPPM 80.503

Comments:
The Contractor has developed a policy which contains a requirement for utilization of a uniform under/overpayment log and a Claims Accuracy report. However, it is not evident that the Contractor has a mechanism in place for the validation of the self-reported information or relies upon the data for determination of systematic errors and corrective actions. During the interview process, it was stated that a dedicated claim processing professional is being sought for oversight of the

Claim Systems

Subcontractors' policies, procedures and reporting validity. A methodology has been developed as a result of AHCCCS corrective action requirements but has not been fully implemented as of this review.

Recommendations:
The Contractor must develop mechanisms for the auditing of claim processing that allow for correction of systemic errors and identification of appropriate provider-level educational interventions. The Contractor must develop internal policies and procedures to ensure the validity of COB information gathered from recipients to minimize the necessity for post-payment recouping.

Claim Systems

Standard
CS 6
The Contractor has a policy or process to notify AHCCCS of any cumulative recoupment greater than $50,000 per Tax Identification Number per contract year. [Contract Section D, Paragraph 25; Attachment F]

Findings: FULL COMPLIANCE
The Contractor notifies AHCCCSA of any cumulative recoupment greater than $50,000 per provider Tax Identification Number per contract year.

Documents Reviewed:
Recoup List by Provider for Flagstaff, Phoenix and Yuma Clinics
Phoenix example of request for recoup
RCPPM 50.200
RCPPM 80.503

Comments:
The Contractor did not provide a recoup request policy for the Tucson clinic but the overlying CRSA policy requires each clinic to notify ADHS/CRSA of all recoup activity that meets the standard. Minimal recovery activity occurred amongst the Subcontractor's during the contract year and evidence of CRSA policy sufficiently meets the requirement of the standard.

Recommendations:
The Contractor should ensure that site-specific recovery policies are in place at each subcontracted clinic.

Claim Systems

Standard
CS 7
The Contractor has a policy or process to request approval from AHCCCS prior to recouping monies from a provider later than 12 months after the date of original payment on a clean claim. [Contract Section D, Paragraph 25]

Findings: FULL COMPLIANCE
The Contractor has a policy or process to request approval from AHCCCS prior to recouping monies from a provider later than 12 months after the date of original payment on a clean claim.

Documents Reviewed:
Phoenix Post Payment Recovery Policy
Yuma Overpayment/Underpayment Policy
Yuma Claims Processing Policy
RCPPM 50.200
RCPPM 80.503

Comments:
The Contractor has a process for requests for approval that meets AHCCCS requirements. However, the lack of uniformity across the subcontractors should be rectified.

Recommendations:
The Contractor should ensure that site-specific recovery policies are in place at each subcontracted clinic.

Claim Systems

Standard
CS 8
The Contractor's health information system collects, analyzes, integrates, and reports data on claim disputes and appeals. [Contract Section D, Paragraph 25; 42 CFR 438.242(a)]

Findings: NON COMPLIANCE
The Contractor's health information system does not collect, analyze, integrate, and report data on claim disputes and appeals.

Documents Reviewed:
Flagstaff Provider Claim Dispute Log for 2006
Phoenix Provider Claim Dispute Log for January 2007
Tucson Provider Claim Dispute Log for 2006
Yuma Provider Claim Dispute Policy
Sample from newly developed database not yet implemented
RCPPM 50.502

Comments:
The Contractor currently has a self-reporting process in place for each clinic that does not allow for validation of reported data and does not consolidate the information for the purposes of tracking and trending. Interview response indicated the development of a central Claim Dispute and Appeal database for the purposes of achieving compliance with this standard. However, no work plan or evidence of implementation was provided to substantiate this statement.

Recommendations:
The Contractor must implement a mechanism for the uniform reporting and validation of claim dispute information in order to track, trend, report and develop interventions in a consolidated manner.

Claim Systems

Standard
CS 9
The Contractor's utilizes data from the claims dispute to adjust operations, as necessary. [Contract Section D, Paragraph 25; 42 CFR 438.242(a)]

Findings: NON COMPLIANCE
The Contractor does not utilize data from the claims dispute to adjust operations, as necessary.

Documents Reviewed:
Flagstaff Provider Claim Dispute Log for 2006
Phoenix Provider Claim Dispute Log for January 2007
Tucson Provider Claim Dispute Log for 2006
Yuma Provider Claim Dispute Policy
Sample from newly developed database not yet implemented
RCPPM 50.502

Comments:
The Contractor is still developing a data collection mechanism. It was not evident that interventions were applied as the result of self-reported data. Individual subcontractors may have developed interventions without Contractor involvement however the oversight of these functions has been fully delegated to the CRS Clinics up to the time of this review.

Recommendations:
The Contractor must develop a procedure for the review of, and response to, data gathered from the newly developed, but as yet unimplemented, centralized repository for Claim Dispute and Appeal information that includes appropriate interventions.

Claim Systems

Standard
CS 10
The Contractor pays interest on all claims, including overturned claims disputes, paid after 60 days of receipt (unless otherwise specified in provider subcontract). [Contract section D, paragraph 25; attachment C2]

Findings: NON COMPLIANCE
The Contractor does not ensure that its Subcontractors pay interest on institutional claims and overturned claims disputes, paid after 60 days of receipt.

Documents Reviewed:
Phoenix report of claims where quick pay/slow pay should have been applied
Yuma Policy – Processing of Facility Claims
RCPPM 50.200

Comments:
The Contractor has a policy in place that contains the exact language of the applicable Statute for payment of institutional claims. However, the individual clinics are not currently following the policy. No information was presented for the Tucson and Flagstaff clinics to support an understanding and effectuation of the statutory requirements.

Recommendations:
The Contractor must ensure that interest penalties are applied to all institutional claims paid after 60 days of receipt.

Claim Systems

Standard
CS 11
The Contractor shows evidence of receiving and paying at least 25% of all claims electronically (excluding claims processed by PBM). [Contract Section D, Paragraph 25]

Findings: NON COMPLIANCE
The Contractor does not ensure that its Subcontractors receive and pay 25% of claims electronically (excluding claims processed by a PBM).

Documents Reviewed:
Phoenix Ad Hoc Report of Claims Received Between 10/06 and 2/07
Phoenix Provider Manual
Yuma Processing of Facility Claims Policy
RCPPM 50.200

Comments:
The Yuma and Phoenix clinics currently offer providers contact information should they be interested and capable of submitting electronic claims. No evidence was presented to demonstrate similar initiatives for the Flagstaff and Tucson clinics. Additionally, only the Phoenix clinic is currently meeting the standard of 25% electronic claim receipts.

Recommendations:
The Contractor must ensure that the subcontracted clinics are capable of accepting electronic claims and that they are sufficiently promoting the utilization of this process.

Claim Systems

Standard
CS 12
The Contractor has a process to audit processing accuracy for both manual and auto adjudicated claims.
[Contract Section D, Paragraph 25]

Findings: PARTIAL COMPLIANCE
The Contractor does not have a process to audit processing accuracy of manually adjudicated claims in place at each Subcontractor.

The Contractor does not have a process to audit processing accuracy of auto adjudicated claims in place at each Subcontractor.

Documents Reviewed:
Flagstaff, Phoenix and Yuma Claim Processing Accuracy Reports for January 2007
Phoenix Claim Audit Policy
Phoenix Claim Adjudication Process Policy
Phoenix Claim Examiner Training Policy
Tucson Project Plan for Claims Processor Training
Tucson Claim Adjudication Policy
Yuma Monthly Claims Accuracy and Data Integrity Report Policy
RCPPM 50.200
RCPPM 80.503

Comments:
The Contractor has delegated claim audit processes to the subcontractors that process the claims. Phoenix, Flagstaff and Yuma clinics were able to present evidence of auditing claim accuracy but unable to demonstrate that the appropriate methodologies were applied to develop the numbers that were reported. Interview response stated that the subcontractors

were just beginning to implement the reporting requirement and therefore not proficient in the report development. The Tucson clinic is still developing a Claim Processor training and audit program in order to report this data.

The development of the standardized report and the sample from three of the subcontractor clinics sufficiently evidence progress toward compliance. However, the questionable reliability of the data (results over 100% in some instances) and the absence of any reporting from the Tucson clinic show that processes are not refined as of this review to appropriately support full compliance with the standard.

Recommendations:
The Contractor must ensure that the subcontracted clinics are able to audit claim accuracy and that reporting is uniform and accurate.

Claim Systems

Standard
CS 13
The Contractor has a quality assurance program that ensures that claims processing personnel are continually monitored to ensure claims are processed to industry standards for accuracy.
[Contract Section D, Paragraph 25; AAC R9-22-703, 705]

Findings: NON COMPLIANCE
CYE ’07 to date the Contractor’s is unable to demonstrate financial accuracy.

CYE ’07 to date the Contractor’s is unable to demonstrate statistical accuracy.

The Contractor does not ensure that its Subcontractors track, analyze and trend errors discovered in the audit program and develops interventions to improve financial and statistical accuracy.

Documents Reviewed:
Flagstaff, Phoenix and Yuma Claim Processing Accuracy Reports for January 2007
Phoenix Claim Audit Policy
Phoenix Claim Adjudication Process Policy
Phoenix Claim Examiner Training Policy
Tucson Project Plan for Claims Processor Training
Tucson Claim Adjudication Policy
Yuma Monthly Claims Accuracy and Data Integrity Report Policy
RCPPM 50.200
RCPPM 80.503

Claim Systems

Comments:
No evidence of processor-level accuracy auditing was presented. Accuracy reports that were presented refer only to aggregate data at the individual sites that were able to report.

Recommendations:
The Contractor must ensure that individual claim processors are subject to accuracy audits.

Claim Systems

Standard:
CS 14
The Contractor has at least monthly aged claims inventory tracking reports.
[42 CFR 438.242(a); CYE 06 Contract No. YH03-0032, Section D, Paragraph 25]

Findings: FULL COMPLIANCE
The Contractor ensures that its subcontractor has adequate claims inventory tracking reports.

Documents Reviewed:
Claim Aging Reports for Each of Four Subcontracted Clinics

Comments:
The Contractor requires the periodic submission of claim aging reports. These reports give a high-level overview of the claims in process and the time to process.

Recommendations:
The Contractor should consider implementation of the requirement to stratify claims in inventory by category of paid; denied; pended for inconsistency and pended for medical review.

Claim Systems

Standard:
CS 15
The Contractor has reports to identify aged claims inventory on the last day of the month.
[42 CFR 438.242(a); CYE 06 Contract No. YH03-0032, Section D, Paragraph 25]

Findings: FULL COMPLIANCE
The Contractor ensures that its subcontractors have adequate reports to identify aged claims on the last day of the month.

Documents Reviewed:
Claim Aging Reports for Each of Four Subcontracted Clinics

Comments:
The Contractor reviews and responds to the submitted claims inventory reports and requires corrective action when appropriate. However, it was noted that the Contractor does not consolidate data for trending purposes.

Recommendations:
The Contractor should consider developing a “roll-up” of the submitted data for trending purposes.

Claim Systems

Standard:
CS 16
The Contractor has policies and procedures in place regarding the adjudication of 90% of all clean claims within 30 days of receipt and 99% of clean claims within 60 days of receipt.
[42 CFR 447.45(d); CYE 06 Contract No. YH03-0032, Section D, Paragraph 25]

Findings: FULL COMPLIANCE
The Contractor ensures that its subcontractors have adequate policy and procedures regarding the required adjudication of 90% of clean claims within 30 days from date of receipt and 99% of clean claims within 60 days of date of receipt.

Documents Reviewed:
RCPPM 50.200
RCPPM 80.503

Comments:
The Contractor has policies in place regarding the adjudication of claims and the review of subcontractor performance for claim processing standards.

Recommendations:
None

Claim Systems

Standard:
CS17
The Contractor adjudicates 90% of all clean claims within 30 days of receipt and 99% of clean claims within 60 days of receipt (unless otherwise specified in provider subcontract).
[42 CFR 447.45(d); CYE 06 Contract No. YH03-0032, Section D, Paragraph 25]

Findings: PARTIAL COMPLIANCE
The Contractor does not ensure that its subcontractors show evidence of claims adjudication 90% of all clean claims within 30 days of receipt and 99% of clean claims within 60 days of receipt.

Documents Reviewed:
Letters to Clinics regarding reported processing rates
Yuma processing policy
RCPPM 50.200
80.503

Comments:
The Yuma and Flagstaff clinics were shown to be in compliance with processing standards. Letters were presented in support of review of the reported processing rates and Phoenix and Tucson were not in compliance with the contractual requirements.

Recommendations:
The Contractor should ensure that all clinics meet the contractual standards for claim processing rates.

Claim Systems

Standard:
CS18
The Contractor voids and adjusts the original encounter when a recoupment is made due to the identification of an erroneously paid claim (claim that should have originally been denied) or when a recoupment is made due to incorrect data or processing (e.g., when demographic, clinical or financial data is changed.)
[CYE 06 Contract No. YH03-0032, Section D, Paragraph 25]

Findings: NON COMPLIANCE
The Contractor does not ensure that its subcontractors have processed an adjustment/voided encounter when a previously paid encounter is later recouped or voided.

Documents Reviewed:
Letters of Review of Clinic Claims

Comments:
CRSA has issued letters to the Phoenix, Tucson and Yuma clinics that state that encounters were not appropriately adjusted or voided based on the Contractor's review of submitted claims data. No evidence was presented in support of compliance with the standard for the Flagstaff clinic.

Recommendations:
The Contractor must ensure that appropriate encounter transactions are submitted by the subcontracted clinics in order that timely and accurate encounter data is forwarded to AHCCCS.

Claim Systems

Standard:
CS19
The Contractor has policies and procedures on reprocessing and paying all overturned claims disputes in a manner consistent with the decision within 10 business days of the decision.
[CYE 06 Contract No. YH03-0032, Section D, ¶25]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor ensures that its subcontractors have adequate policy and procedures describing the reprocessing and paying of overturned claims disputes, consistent with the decision, within 10 business days of the decision.

Documents Reviewed:
Flagstaff and Phoenix Provider Manuals
Flagstaff, Phoenix and Yuma Claim Disputes Policies
Phoenix Claim Adjudication Process Policy
CRSA Claim Dispute Case File Review Tool
RCPPM 50.503
RCPPM 80.503

Comments:
The Contractor provided no evidence of its Tucson subcontractor maintaining an appropriate policy or procedure regarding the processing of overturned claim disputes. CRSA monitors 100% of claim disputes from the contractors in order to ensure compliance with the mandated timeframes but was unable to provide evidence of timely payment for all subcontractors.

Recommendations:
The Contractor must require all subcontracted clinics to maintain policies and procedures that ensure the reprocessing of overturned claim disputes in a timely manner.

Claim Systems

Standard:
CS20
The Contractor reprocesses and pays all overturned claims disputes in a manner consistent with the decision within 10 business days of the decision.
[CYE 06 Contract No. YH03-0032, Section D, Paragraph 25]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor ensures that its subcontractors show evidence of reprocessing and paying all overturned claims disputes in a manner consistent with the decision, within 10 days of the decision.

Documents Reviewed:
Flagstaff and Phoenix Provider Manuals
Flagstaff, Phoenix and Yuma Claim Disputes Policies
Phoenix Claim Adjudication Process Policy
Tucson Claim Dispute Log for 2006
CRSA Claim Dispute Case File Review Tool
RCPPM 50.503
RCPPM 80.503

Comments:
The Contractor stated that 100% of claim disputes are reviewed by CRSA to ensure compliance and presented an example of a completed review tool to evidence this process. However, the tool that was presented showed that the claim dispute was closed within the appropriate timeframe but did not clearly indicate the date on which payment was made.

Recommendations:
The Contractor should ensure that a record of the date of payment is maintained with the claim dispute file and in any data warehousing application.

Claim Systems

Standard:
CS21
Claims processing personnel are formally trained to process the CRS claims
[AAC R9-22-705; CYE 06 Contract No. YH03-0032, Section D, Paragraph 25]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor does not consistently ensure that its Subcontractor's claims processing personnel are trained to process CRS claims.

The Contractor does not consistently ensure that its Subcontractor's claims processing receive regular and periodic claims processing in-service training.

Documents Reviewed:
Flagstaff Claim Processing Training Log for 6/06-12/06
Phoenix Claim Processing Training Log for the quarter ending 12/31/06
Tucson Project Plan for Development of Claim Training
Yuma Claims Training Log for 6/06-12/06
Phoenix Policy for Claims Adjudicator Training
RCPPM 50.200

Comments:
The supporting evidence shows that Tucson has not implemented an adequate training program as of the date of the review.

Recommendations:
The Contractor should ensure that all subcontractor claims processing personnel are adequately trained on the processing of CRS related claims for payment and that periodic update occurs.

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Cultural Competency/Limited English Proficiency

AHCCCS REVIEW TEAM:	Rodd Mas, Manager, Acute Care Operations Kate Aurelius, Assistant Director Gina Aker, Compliance & Operations Officer Maureen Wade, Manager, Medical Management
CONTRACTOR STAFF:	Judy Walker, Division Chief, Clinical Programs Stephen Burroughs, Chief, Quality Management Margery Sheridan, Chief, Consumer Rights Joan Agostinelli, Administrator Jennifer Vehonsky, Division Chief, Compliance Norma Garcia-Torres, Cultural Competency Coordinator
DATE OF REVIEW:	**March 12 through March 16, 2007**

Cultural Competency/Limited English Proficiency

Standard
CUC/LEP 1
The Contractor has a written and approved cultural and linguistic program for the audit period describing the Contractor's activities related to complying with culture and linguistic requirements.
[Contract, Section D, Paragraph 48; AHCCCS ACOM Cultural Competency Policy; 42 CFR 438.206(c)(2)]

Findings: FULL COMPLIANCE
The CUC/LEP Program includes a description of the required activities, methods used to implement and identify CUC/LEP- improvement initiatives and responsible staff.

Documents Reviewed:
9/26/07 Cultural Competency Approval Letter from AHCCCS
9/27/07 CYE 2007 CRSA Recipient
Cultural Competency Committee Objectives

Comments:
The Contractor has done particularly well in determining the cultural needs of its recipients. The cultural needs of this population is driven primarily by the needs and limitations presented by the recipients disabilities, and secondarily by language and ethnicity. The Contractor utilizes parent action councils to participate in the development of all recipient materials.

Recommendations:
None

Cultural Competency/Limited English Proficiency

Standard
CUC/LEP 2
The Contractor has policies or processes that ensure compliance with meeting CUC/LEP program requirements; Plan has updated and approved policies or processes on 1) Access to Interpretation Services 2) Translation Services 3) Cultural Competency Trainings 4) Ensuring qualifications of bilingual staff.
[Contract, Section D, Paragraph 9 & 48; AHCCCS ACOM Cultural Competency Policy; 42 CFR 438.206(c)(2), 438.10(c)(4), 438.10(c)(4&5).]

Findings: PARTIAL COMPLIANCE
The Contractor has policies or processes on Access to Interpretation Services.

The Contractor has policies or processes on Translation Services.

The Contractor does not have policies or processes on Cultural Competency Trainings.

The Contractor does not have processes to ensure qualifications of multilingual staff.

Documents Reviewed:
CRSA Regional Contractor Provider Manual Chapter 40.00 & 80.00
Website Monitoring Tool
Cultural Competency Plan

Comments:
(CYE06 OFR CUC2, CUC3; CYE05 OFR CUC1.4, CUC2.2)
The Contractor is currently initiating a testing protocol for all staff member utilized for translation and interpretation services and implementing a pay differential for those staff. While chapter 80.00, Section 23 requires the Regional Contractors to ensure the qualification of the multilingual staff and training, Contractor was unable to provide policies and

procedures for two of the Regional Contractors Cultural Competency training or how the Contractor ensures qualifications of its multilingual staff. During the interview, the Contractor's staff noted the Annual Administrative Review will be used to monitor if the Regional Contractors are training their staff and determine if the multilingual staff are qualified to provide interpretation and translation services. These have not been completed as of yet.

Recommendations:
The Contractor/Regional Contractors must have policies or processes on Cultural Competency Trainings.

The Contractor/Regional Contractors must have processes to ensure qualifications of multilingual staff.

Cultural Competency/Limited English Proficiency

Standard:
CUC/LEP 3
The Contractor maintains a cultural competency training program for its employees.
[Contract, Section D, Paragraph 48; AHCCCS ACOM Cultural Competency Policy; 42 CFR 438.206(c)(2)]

Findings: NON COMPLIANCE
The Contractor has not provided a cultural competency orientation for its employees.

The Contractor does not have evidence of ongoing training and evaluations of Contractor staff providing culturally and linguistically appropriate services to members.

The Contractor has not developed a methodology to assess the cultural competency of its employees.

The Contractor does not modify training content based on deficiencies noted in the assessments.

Documents Reviewed:
CRSA LEP & Language Access Services 3/7/07
CRSA Contractors Training 3/8/07
Language Line Services Training Kit
CRSA Website
St. Joseph Provider Training
Tucson Provider Training Curriculum
1/27/07 Provider Cultural Competency Training

Comments:
(CYE06 OFR CUC2; CYE05 OFR CUC1.4)

Cultural Competency/Limited English Proficiency

The Contractor has not trained its staff on Cultural Competency. While the Contractor provided a sign-in sheet for 3/7/07 training, it listed only seven (7) staff members. The Contractor is currently piloting an E-Learning Module which will be used to training the Contractor's staff initially and annually thereafter. The Contractor was unable to provide evidence of three (3) of the Regional Contractors provider training. St. Joseph provides detailed provider training information which could be adapted by the other Regional Contractors to train their providers.

Recommendations:
The Contractor must provide a cultural competency orientation for its employees.

The Contractor must provide ongoing training and evaluations of Contractor staff providing culturally and linguistically appropriate services to members.

The Contractor must develop a methodology to assess the cultural competency of its employees.

The Contractor must modify training content based on deficiencies noted in the assessments.

Cultural Competency/Limited English Proficiency

Standard
CUC/LEP 4
The Contractor has evidence of performing initial provider orientations on cultural competency and ongoing reviews/updates to providers covering the provisions of culturally competent services to members. [Contract, Section D, Paragraph 48; AHCCCS ACOM Cultural Competency Policy; 42 CFR 438.10(c)(4)]

Findings: PARTIAL COMPLIANCE
The Contractor does not have a provider-training schedule for the audit period.

The Contractor does not have evidence of provider orientation and/or training materials that provide education on cultural and linguistic contractual requirements.

The Contractor has evidence of provider or staff trainings during the audit period on a members' right to request and receive interpretation services.

The Contractor provides additional resources cultural competency if requested by provider.

Documents Reviewed:
3/7/07 CRSA Regional Contractors Training
Language Line Services Training Kit
CRSA Website
St. Joseph Provider Training
Tucson Provider Training Curriculum
- ✓ 1/27/07 Provider Cultural Competency Training

Cultural Competency/Limited English Proficiency

Comments:
The Contractor was able to provide evidence of its efforts to train the Regional Contractors' administration on the Cultural Competency requirements. However, only Tucson and St. Joseph provided evidence that the providers were appropriate trained. Yuma and Flagstaff did not provide evidence that the providers received training.

Recommendations:
The Contractor must have a provider-training schedule for the audit period.

The Contractor must have evidence of provider orientation and/or training materials that provide education on cultural and linguistic contractual requirements.

The Contract should consider standardizing the Cultural Competency Training for the providers at the Regional Contractor level.

Cultural Competency/Limited English Proficiency

Standard
CUC/LEP 5
The Contractor uses a communication method, other than the member handbook, to notify members that information and materials are available in other languages and formats. [Contract, Section D, Paragraph 48; ACOM Cultural Competency Policy; 42 CFR 438.10(c)(4); Civil Rights Act (1964) Title VI]

Findings: NON COMPLIANCE
The Contractor does not use a communication method, other than the member handbook, to notify members that information and materials are available in other languages.

The Contractor does not use communication methods, other than the member handbook, to notify members that information and materials are available in other formats.

Documents Reviewed:
CUC/LEP Matrix Grid for Member Materials in Alternative Languages
Member Handbook
CRSA Member Information Letter
CCP Evaluation CYE 06
CCP CYE 07

Comments:
(CYEY06 OFR CUC4; CYE05 OFR CUC2.3)
The information provided by the Contractor did not provide evidence that they notify members that information and materials are available in other languages and formats. During the interview the staff offered to provide additional documentation. The information was not provided.

Cultural Competency/Limited English Proficiency

Recommendations:
The Contractor must use communication methods, other than the member handbook, to notify members that information and materials are available in other formats and languages.

Cultural Competency/Limited English Proficiency

Standard
CUC/LEP 6
The Contractor has identified and translates all member materials into prevalent languages.
[Contract, Section D, Paragraph 9 & 48; ACOM Cultural Competency Policy; 42 CFR 438.10(c)(3), 438.10(c)(5), 438.10(c)(5)(ii)]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has not identified all its prevalent languages.

The Contractor translates the following materials:
- ✓ Recipient Handbook
- ✓ Recipient Newsletters
- ✓ Generic Correspondence
- ✓ Notices of Action

Documents Reviewed:
Recipient Handbook
Recipient Newsletters
Member Information Letter
Sample Correspondence
Notices of Action

Comments:
(CYE05 OFR LEP 1.1)
While Contractor translates all recipient materials into English and Spanish, there is no a mechanism in place to identify the prevalent languages of the population.

Cultural Competency/Limited English Proficiency

Recommendations:
The Contractor should identify all prevalent languages spoken by its membership.

Cultural Competency/Limited English Proficiency

Standard
CUC/LEP 7
The Contractor offers member materials in alternative languages and formats.
[Contract, Section D, Paragraph 8, 9 & 48; ACOM Cultural Competency Policy; CFR 438.10(c)(3), 438.10(c)(5), 438.10(c)(5)(ii)]

Findings: FULL COMPLIANCE
The Contractor offers member materials in alternative languages and formats.

The Contractor does not have system in place to track member requests for member informing materials in alternative languages; evidence of fulfilling member requests. (FYI)

Documents Reviewed:
Recipient Handbook
CUC/LEP Matrix Grid

Comments:
(CYE05 OFR LEP 1.3)
None

Recommendations:
None

Cultural Competency/Limited English Proficiency

Standard
CUC/LEP 8
The Contractor has systems in place to ensure access to interpreter and translation services for all Limited English Proficiency (LEP) members at key points of contact within the Contractor. [Contract, Section D, Paragraph 8 & 48; ACOM Cultural Competency Policy; CFR 438.10(c)(3), 438.10(c)(4), 438.10(c)(5), 438.10(c)(5)(ii); Civil Rights Act (1964) Title VI]

Findings: NON COMPLIANCE
The Contractor's has an approved policy and process for staff to provide interpretation and translation services to members.

The Contractor does not have documentation on the results of language proficiency assessments of Plan staff.

The Contractor does not evidence of qualifications for all staff that are utilized to provide interpretation services to members (e.g., certificates, testing scores, qualifications of vendors, etc.).

Documents Reviewed:
GA1.6 Language Assistance Services for CRSA & CRS Regional Contractors
Contract Solicitation #DES060043-A1
CRS Regional Contractor CLAS Standards Assessment Tool

Comments:
(CYE05 OFR LEP 1.2)
The Contractor utilizes the State's translation & interpretation services at the administrative level. They are currently formalizing a process to assess the language and translation proficiency of the staff. The Contractor has added standards

to its draft Annual Administrative Tool to monitor the Regional Contractors language and translation proficiency and the qualification of the staff. However, it has not been completed to date.

Recommendations:
The Contractor must ensure the staff providing interpretation or translation services is qualified and proficient.

Cultural Competency/Limited English Proficiency

CUC/LEP 9
The Contractor ensures that interpreter services are available at provider appointments.
[Contract, Section D, Paragraph 8 & 48; ACOM Cultural Competency Policy; 438.10(c)(4), 438.10(c)(5), 438.10(c)(5)(ii)]

Findings: FULL COMPLIANCE

The Contractor ensures that interpreter services are available at provider appointments.

The Contractor has interpreter services for the hearing impaired at provider appointments.

The Contractor's and/or provider has a contract with interpretation services agency for free face-to-face and telephonic interpreter service in place during the audit period.

Data on interpretation services requested by members is not gathered and analyzed by staff to ensure adequate access for members.

Documents Reviewed:
Language Line Services for CRSA & CRS Regional Contractors GA 1.6
Telemedicine Reports
ALTA Language Service
Hands Above the Rest Interpreting Service, Inc. DES060048
Finger Works, Inc DES060048

Comments:
The Regional Contractors utilize the hospitals' contracts to provide interpreter services at the clinic level. The Yuma, Phoenix and Tucson clinics are contracted CyraCom, Flagstaff is contracted with InSync Interpreters. The hospitals do not distinguish between CRSA recipients and the general patient population. The service is posted and available to all

persons visiting the hospital. Additionally, the Contractor is unable to analyze the usage of the language lines because the hospitals do not aggregate the data at the clinic level.

Recommendations:

The Contractor should data on gather and analyzed interpretation services requested by their recipients to ensure adequate access for members.

Cultural Competency/Limited English Proficiency

Standard
CUC/LEP 10
The Contractor has a monitoring and oversight system in place to evaluate that Regional Contractors are compliant with the AHCCCS program's cultural and linguistic requirements. [Contract, Section D, Paragraph 8, 48, 39; ACOM Cultural Competency Policy; CFR 438.10(c)(3), 438.10(c)(5), 438.10(c)(5)(ii), 438.230(a), 438.230(b)]

Findings: PARTIAL COMPLIANCE
The Contractor has a system in place to ensure that identified CUC/LEP-related deficiencies are corrected.

The Contractor's does not have evidence that Contractor staff has worked to correct provider office deficiencies discovered through oversight efforts.

The Contractor has evidence that Contractor has clear contractual requirements in place with its contracted providers in relation to fulfilling cultural and linguistic requirements.

Documents Reviewed:
CRS Regional Contractors' CLAS Standards Assessments
Policy and Procedures Manual
Chapter 80
Cultural Competency Measure – CRS 2006 Family Centered Survey

Comments:
(CYE05 OFR LEP 1.2)
The Contractor has updated all the Regional Contractors' contracts to include cultural and linguistic requirements. The Contractor has completed a Cultural Competency Assessment of each clinic uses the CLAS standards and 2006 OFR

findings as a baseline. The Contractor will readdress during the Annual Administrative Review. At this point, the Contractor can not demonstrate corrective action implementation and monitoring at the Regional Contractor level.

Recommendations:
The Contractor's must provide evidence that the Contractor staff has worked to correct provider office deficiencies discovered through oversight efforts.

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delivery Systems

AHCCCS REVIEW TEAM:

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Jennifer Vehonsky, Division Chief, Compliance

DATE OF REVIEW: **March 12 through March 16, 2007**

Delivery Systems

Standard
DS 1
The Contractor educates the provider network regarding AHCCCS appointment standards.
[Contract Section D, Paragraph 10, 30, 31, 15; AMPM Ch. 300; AAC R9-22-502;]

Findings: FULL COMPLIANCE
The Contractor educates its Subcontractor and ensures that its Subcontractor educates its provider network regarding appointment standards.

Documents Reviewed:
CRSA Contract with regional CRS sites: Task 4
Provider Manual, Chapter 6, pg. 6-2
Provider Orientation Checklist

Comments:
None

Recommendations:
None

Delivery Systems

Standard
DS 2
Reserved

Delivery Systems

Standard
DS 3
The Contractor monitors clinic appointments ensuring availability within 45 days of referral. [Contract Section D, Paragraph 10, 30, 31, 15; AMPM Ch. 300; AAC R9-22-502]

Findings: NON COMPLIANCE
The Contractor does not monitor its Subcontractor to ensure clinic appointments availability within 45 days of referral is met.

Documents Reviewed:
New Member Enrollment Report
45 Day Referral Report – July 1, 2006 to December 31, 2006 (Flagstaff, Tucson, Yuma, and Phoenix)
Current Member Referral Report

Comments:
(CYE06 OFR DS6; CYE05 OFR DS2.2)
The Contractor's monitoring reports do not show the actual average number of days from referral that routine specialty care appointments are available. However, the Contractor does report that from July 2006 through January 2007 its overall compliance with this standard was only 39%.

Recommendations:
The Contractor must improve its oversight of its Subcontractors to ensure that the AHCCCS standard for clinic appointment availability within 45 days of referral is met. The Contractor should consider developing a reporting methodology that monitors, per clinic, the number of days from referral, that routine specialty care appointments are available.

Delivery Systems

Standard
DS 4
Reserved

Delivery Systems

Standard
DS 5
Reserved

Delivery Systems

Standard
DS 6
The Contractor has and applies a methodology monitoring a member's waiting time within the office for a scheduled appointment is no more than 45 minutes, except when the provider is unavailable due to an emergency. [Contract Section D, Paragraph 10, 30, 31, 15; AMPM Ch. 300; AAC R9-22-502]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor has and applies a methodology monitoring a member's waiting time within the office for a scheduled appointment.

Documents Reviewed:
2006 Family Satisfaction Survey & Results (Annual)
2006 Family Satisfaction Questionnaire

Comments:
(CYE06 OFR DS6; CYE05 OFR DS2.2)

The Contractor presently relies on an annual telephonic satisfaction survey to assess member waiting times.

Recommendations:
The Contractor should consider increasing the frequency of the telephonic survey and/or conducting periodic on-site visits to randomly assess actual office wait times.

Delivery Systems

Standard
DS 7
The Contractor applies corrective action when the provider does not comply with AHCCCSA appointment standards. [Contract Section D, Paragraph 10, 30, 31, 15; AMPM Ch. 300; AAC R9-22-502]

Findings: NON COMPLIANCE
The Contractor does not apply corrective action/s when the provider does not comply with AHCCCS appointment standards.

Documents Reviewed:
Phoenix CYE 07 Appointment Timelines and System
General Administration Policy
QM Policy (QM1.3), Performance Measures
Administrative Review Tool: QM7
Request for CAP for Tucson
CAP Acceptance Letter from Phoenix

Comments:
The Contractor has a corrective action process but does not apply the process such that it results in Subcontractor and/or provider compliance with AHCCCSA appointment standards.

Recommendations:
The Contractor must employ a corrective action process that results in Subcontractor and/or provider compliance with AHCCCCS appointment standards. This must include a process for identifying the root cause of the problem, monitoring the execution of the corrective action plan, and taking definitive action to remedy continued non-compliance.

Delivery Systems

Standard
DS 8
Reserved

Delivery Systems

Standard
DS 9
Reserved

Delivery Systems

Standard
DS 10
Reserved

Delivery Systems

Standard
DS 11
Reserved

DS 12
Provider Services Representatives are adequately trained. [Contract Section D, Paragraphs 27, 29, and 35]

Findings: NON COMPLIANCE
Provider Services Representatives do not receive an orientation.

Provider Services Representatives do not receive ongoing training to handle provider inquiries and to educate providers and office staff about AHCCCS and Contractor requirements.

Documents Reviewed:
None

Comments:
The Contractor notes that it does not employ any provider services representatives since provider services are delegated to the CRS Regional Contractor sites. This notwithstanding, the standard requires the Contractor to evidence that provider services representatives are adequately trained. Even as a delegated function the Contractor holds ultimate responsibility for ensuring that the standard is met.

Recommendations:
The Contractor must develop a policy and process for ensuring that Provider Services Representatives are adequately trained. The process must include an orientation and on-going training for Provider Services Representations. In the event the Contractor continues to delegate the provider services function to Subcontractors, the Contractor must maintain sufficient oversight of and coordination with Subcontractors to ensure that Provider Services Representatives are adequately trained.

Delivery Systems

Standard
DS 13
Reserved

Delivery Systems

Standard
DS 14
Reserved

Delivery Systems

Standard
DS 15
The Contractor has evidence of revising its policy and procedure manual to incorporate program changes including but not limited to regulatory/legislative/contractual updates as well as the Contractors administrative process changes. [Contract Section D, Paragraph 16]

Findings: FULL COMPLIANCE
The Contractor has evidence of providing updates on the policy and procedure manual to its Subcontractor during the audit period.

Documents Reviewed:
Tracking document for CRS Policy Manual
Tracking document for CRS RCPPM

Comments:
(CYE06 OFR DS8; CYE05 OFR DS3.4)
None

Recommendations:
None

Delivery Systems

Standard
DS 16
The Contractor ensures that each contracted provider is made aware of a website policy and procedure manual or, if requested, issued a hard copy. [Contract Section D, Paragraph 52]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor notify each contracted provider that the policy and procedure manual is available on the website, if requested, issues a hard copy.

Documents Reviewed:
CRS Regional Contractor's Contracts, Task 34, language on website requirements
Sample of Provider Newsletter from Phoenix

Comments:
None

Recommendations:
None

Delivery Systems

Standard
DS 17
Reserved

Delivery Systems

Standard
DS 18
Contractor has a policy/process for training new providers.
[Contract Section D, Paragraph 27, 29, 37; 42 CFR 438.206 (a)]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor has an approved policy/process for training new providers.

Documents Reviewed:
Provider Manual, page 4

Comments:
None

Recommendations:
None

Delivery Systems

Standard
DS 19
The Contractor has evidence that contracted providers receive adequate and appropriate provider education materials on an ongoing basis. [Contract Section D, Paragraph 18]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor ensures that its Subcontractor has and applies a methodology for distributing provider education materials to Contractor's provider network.

On-site provider visits are not made on a regular periodic basis.

Documents Reviewed:
Grievance training: Agenda and sign-in sheets for October 26, 2006 and January 17, 2007
Screen shots of e-learning Grievance Training Module
NOA Training: Agenda and sign-in sheets for September 25, 2006
QOC Training Binder

Comments:
(CYE06 OFR DS11)
Although the Contractor provided evidence that contracted providers initially receive adequate and appropriate provider education materials, there was no evidence that contracted providers receive education materials on an ongoing basis.

Recommendations:
The Contractor should ensure contracted providers receive provider education materials on an ongoing basis.

Delivery Systems

Standard
DS 20
Contractor has evidence of updating its network providers on new or changing program standards and guidelines. [Contract Section D, Paragraph 18, 35; 42 CFR 438.206(a)(2]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor has evidence of updating its network providers on new or changing program standards and guidelines.

Documents Reviewed:
Letters and emails of notification to Regional Contractors of policy revisions
Provider network policies and procedures
Website information

Comments:
None

Recommendations:
None

Delivery Systems

Standard
DS 21
The Contractor notifies providers at least 30 days in advance of a material change to a program or process.
[Contract Section D, Paragraph 9]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor notifies providers at least 30 days in advance of a material change to a program or process.

Documents Reviewed:
RCPPM 80.60,0 (Chapter 80, Section 600): Provider Network and Development Plan
See letters/emails from Regional Contractors to CRSA

Comments:
None

Recommendations:
None

Delivery Systems

Standard:
DS22
Contractor must submit a written description of covered services to AHCCCS Division of Health Care Management (DHCM) by July 1 annually. [Contract, Section D, Paragraph 2]

Findings: FULL COMPLIANCE
Contractor reported covered services to AHCCCSA, Division of Health Care Management (DHCM) by July 1 annually.

Documents Reviewed:
DHCM Approval Letters

Comments:
None
(CYE06 OFR DS1; CYE05 OFR DS1.1)

Recommendations:
None

Delivery Systems

Standard:
DS23
Contractor must send a consultation report to the referring physician and Acute/ALTCS Contractor within 30 days of first CRS clinic visit. [Contract, Section D, Paragraph 2]

Findings: NON COMPLIANCE
Contractor does not show evidence of sending a consultation report to the referring and Acute/ALTCS Contractor within 30 days of first CRS clinic visit.

Documents Reviewed:
CRSA Administrative Review: QM11
New Member Enrollment Worksheet
Examples of Dictation

Comments:
(CYE06 OFR DS2; CYE05 OFR DS1.3)
Although the Contractor provided evidence of a consultation report and a corrective action plan related to Subcontractor non-compliance with the appointment standard, there was insufficient information to determine if the consultation reports are sent to the referring physician and Acute/ALTCS Contractor within 30 days of the first CRS clinic visit.

Recommendations:
The Contractor must develop a procedure for documenting and ensuring that consultation reports are sent to the referring physician and Acute/ALTCS Contractor within 30 days of the first CRS clinic visit.

Delivery Systems

Standard:
DS24
Contractor and/or its subcontractor must send a monthly clinic report to the Acute/ALTCS Contractor's Medical Director documenting the recipient's scheduled appointment, whether appointments are kept, which clinic the recipient is attending and the status of the recipient. [Contract, Section D, Paragraph 2]

Findings: NON COMPLIANCE
Contractor and/or its subcontractor does not send a monthly clinic report to the Acute/ALTCS Contractor's Medical Director documenting the recipient's scheduled appointment, whether appointments are kept, which clinic the recipient is attending and the status of the recipient.

Documents Reviewed:
No Show Report
No Show Data: Phoenix, Tucson, Flagstaff and Yuma

Comments:
(CYE06 OFR DS3; CYE05 OFR DS1.4)
The Contractor provided a No Show Report with aggregated data related to recipient activity within the respective clinic. However, the Contractor did not provide recipient specific data related to the recipient's scheduled appointment, whether appointments are kept, which clinic the recipient is attending and the status of the recipient.

Recommendations:
The Contractor must develop and submit a monthly recipient specific clinic report to the Acute/ALTCS Contractor's Medical Director in compliance with the standard.

Delivery Systems

Standard:
DS25
Contractor has a policy that states medically necessary non-emergency transportation will be coordinated with the recipient's health plan. [Contract, Section D, Paragraph 2]

Findings: FULL COMPLIANCE
Contractor has a policy that states medically necessary non-emergency transportation will be coordinated with the recipient's Acute/ALTCS Contractor.

Documents Reviewed:
Intersite Treatment and Transfer Policy
CRS RCPPM, Chapter 40, Section 40.902, Transportation

Comments:
(CYE06 OFR DS5)
None

Recommendations:
None

Delivery Systems

Standard:
DS26
CRSA must ensure that an initial medical evaluation is scheduled within 30 days of the preliminary medical determination. [Contract, Section D, Paragraph 2**]**

Findings: NON COMPLIANCE
CRSA does not ensure that an initial scheduled medical evaluation is scheduled within 30 days of the preliminary medical determination.

Documents Reviewed:
New Member Enrollment Report
CAP Acceptance Letter for Tucson
Request for CAP for Tucson
CRSA Application Checklist and supporting documentation

Comments:
(CYE06 OFR DS7; CYE05 OFR DS2.3)
During the reporting period of July 2006 through January 2007, only one Subcontractor (i.e.: Flagstaff) was compliant with the standard for ensuring that the initial medical evaluation is scheduled within 30 days of the preliminary medical determination. The breakdown per clinic is as follow:

Flagstaff – 85.6%
Phoenix – 37.6%
Tucson – 50.3%
Yuma – 63.0%

Recommendations:
Contractor must ensure that the initial medical evaluation is scheduled within 30 days of the preliminary medical determination.

Delivery Systems

Standard:
DS27
Contractor must have policies and procedures that describe how services will be provided and how to arrange for medically necessary services should the CRS network become temporarily insufficient.
[Contract, Section D, Paragraph 2]

Findings: FULL COMPLIANCE
Contractor has policies and procedures that describe how services will be provided and how to arrange for medically necessary services should the CRS network become temporarily insufficient.

Documents Reviewed:
RCPPM 80.600 (Chapter 80, Section 600); Provider Network Development and Management Plan
Provider Manual approval letters
Provider Manual Checklist
CRS PCPPM, Chapter 80

Comments:
(CYE06 OFR DS9; CYE05 OFR DS3.5)
None

Recommendations:
None

Delivery Systems

Standard:
DS28
Contractor provider manual and its subcontractor's manuals must meet contractual requirements as stated in the contract. [Contract, Section D, Paragraph 2]

Findings: FULL COMPLIANCE
CRSA provider manual and its subcontractor's manuals meet contractual requirements as stated in the contract.

Documents Reviewed:
New Member Enrollment Report
Administrative Review Tool: QM11
CAP Acceptance Letter from Phoenix
Request for CAP for Phoenix

Comments:
(CYE06 OFR DS10; CYE05 OFR DS4.1)
None

Recommendations:
None

Delivery Systems

Standard:
DS29
The Contractor determination process for participating in the CRS program includes a 10-day approval notice to health plans/program contractors and providers. [Contract, Section D, Paragraph 2]

Findings: FULL COMPLIANCE
The Contractor determination process for participating in the CRS program includes a 10-day approval notice to health plans/program contractors and providers.

Documents Reviewed:
Contractor letters/correspondence to Subcontractors
CRS Policy and Procedure: Medical eligibility

Comments:
(CYE06 OFR DS12; CYE05 OFR DS9.1)
None

Recommendations:
None

Delivery Systems

Standard:
DS30
Reserved

ADHS/CRSA

AHCCCS OFR Standards

CYE 2007

Encounters

AHCCCS REVIEW TEAM: Brent Ratterree, Encounters Manager
Robert Russ, Data Analysis and Research Supervisor

CONTRACTOR STAFF: No Formal Interview Occurred

Encounters

Statistical Measures Methodology

- Total possible points are assigned for each form type (A, C, D, I, L, O) submitted by the peer group (all acute Contractors) and Contractor. For aged pended encounters the total possible points is not subdivided for each form type.
- For the measurement period, e.g., CYE06, a mean, one standard deviation and two standard deviations are calculated. Only one tail of the standard deviation results in a reduction of possible points, e.g., for aged pended encounters a higher ratio than the upper standard deviation will lose points whereas a lower ratio than the lower standard deviation will receive full points.
- For each form type the Contractor's results: (1) not exceeding one standard deviation receives 100% of the assigned points; (2) greater than one standard deviation but not exceeding two standard deviations receives 50% of the assigned points; and (3) exceeding two standard deviations receives 0% of the assigned points.
- Points are totaled and multiplied by the weight to determine the compliance score.
- If the Contractor's data is determined to be an outlier, AHCCCS reserves the right to exclude the data from the peer group.

ADHS/CRSA

AHCCCS OFR Standards

CYE 2007

Encounters

Standard:
ENC 1
The Contractor's ratio of adjudicated encounters by month of service is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: SUBSTANTIAL COMPLIANCE
For CYE06, a ratio of adjudicated encounters by month of service per paid member month is calculated and compared to the statistical measures described above from the peer group total mean

For March 2006 through February 2007, a ratio of adjudicated encounters by month of service per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2006 through February 2007.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
The Contractor's data is consistently below one standard deviation for professional and drug encounter submissions.

Recommendations:
The Contractor should continue its efforts to ensure all encounters are submitted completely, timely and accurately. Contractor must review its system processes to validate that all CRS paid claims are encountered to AHCCCS.

Encounters

Standard:
ENC 2
The Contractor's ratio of encounters processed is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For CYE06, a ratio of processed encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean.

For March 2006 through February 2007, a ratio of processed encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2006 through February 2007.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 3
The Contractor's ratio of new day encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For CYE06, a ratio of new day encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean.

For March 2006 through February 2007, a ratio of new day encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2006 through February 2007.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 4
The Contractor's ratio of approved encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For CYE06, a ratio of approved encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean.

For March 2006 through February 2007, a ratio of approved encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2006 through February 2007.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 5
The Contractor used the provider education/training sanction dollars from the data validation results for provider education and training. [Contract Section D, Paragraph 36]

Findings: NOT APPLICABLE
Currently the Contractor is not evaluated in the data validation study. For this standard the Contractor can not be evaluated.

Documents Reviewed:
Provider education documentation from the Contractor was not available.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 6
The Contractor's sample of paid claims is completely, accurately, and timely encountered. [Contract Section D, Paragraph 36]

Findings: PARTIAL COMPLIANCE
_184_ of _308_ (59.7%) paid claims were submitted as complete, accurate and timely encounters.

Documents Reviewed:
Claims copies submitted by Contractor

Comments:
A consistent pattern of professional claim omissions were found for Walgreens Home Care paid claims. Omissions for this provider accounted for nearly 2/3 of all CRS omissions.

Recommendations:
The Contractor should continue its efforts to ensure all encounters are submitted completely, timely and accurately. Contractor must review its system processes to validate that all CRS paid claims are encountered to AHCCCS.

Encounters

Standard:
ENC 7
The Contractor's ratio of total pended encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For CYE06, a ratio of total pended encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean.

For March 2006 through February 2007, a ratio of total pended encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2006 through February 2007.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 8
For the most recent quarter, the Contractor's ratio of total pended encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For the quarter ending February 2007, a ratio of total pended encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean.

For the quarter ending February 2007, a ratio of total pended encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from the quarter ending February 2006.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 9
The Contractor's ratio of aged pended (pended greater than 120 days) encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For CYE06, a ratio of aged pended encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean.

For March 2006 through February 2007, a ratio of aged pended encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2006 through February 2007.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 10
For the most recent quarter, the Contractor's ratio of aged pended (pended greater than 120 days) encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For the quarter ending February 2007, a ratio of aged pended encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean.

For the quarter ending February 2007, a ratio of aged pended encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from the quarter ending February 2006.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 11
The Contractor's ratio of newly pended (pended less than 30 days) encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For CYE06, a ratio of newly pended encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total.

For March 2006 through February 2007, a ratio of newly pended encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2006 through February 2007.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

Encounters

Standard:
ENC 12
The Contractor's ratio of pended to approved encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 36]

Findings: FULL COMPLIANCE
For CYE06, a ratio of pended to approved encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean.

For March 2006 through February 2007, a ratio of pended to approved encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2006 through February 2007.

Documents Reviewed:
Administrative encounter and recipient data.

Comments:
None

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

General Administration

AHCCCS REVIEW TEAM:	David Bjorn, Compliance & Operations Officer Rodd Mas, Manager, Acute Care Operations Kate Aurelius, Assistant Director Gina Aker, Compliance & Operations Officer
CONTRACTOR STAFF:	Joan Agostinelli, Administrator Cynthia Layne, Chief Financial Officer Jennifer Vehonsky, Division Chief, Compliance Marta Urbina, Clinical Program Executive Coordinator Tim Stanley, Compliance Officer
DATE OF REVIEW:	**March 12 through March 16, 2007**

General Administration

Standard
GA 1
The Contractor has policies and procedures for the maintenance of records under Federal and State guidelines and can provide those records, when requested.
[Contract Section D, Paragraph 33; 42 CFR 164.53 and 438.6(g)]

Findings: FULL COMPLIANCE
The Contractor has policies and procedures for the maintenance of records under Federal and State guidelines and can provide those records, when requested.

Documents Reviewed:
RCPPM Chapter 70

Comments:
None

Recommendations:
None

General Administration

Standard
GA 2
Reserved

General Administration

Standard
GA 3
The Contractor has a process to ensure that all contracts/agreements are loaded accurately and timely.
[Contract Section D, Paragraph 25]

Findings: NON COMPLIANCE
The Contractor does not have a process to ensure that all contracts/agreements are loaded in an accurately and timely.

Documents Reviewed:
Clinic contracts

Comments:
The Contractor did not provide evidence that policy or procedure has been developed to ensure that physician contracts are loaded in a timely manner. Additionally, no documentation of oversight for this process was presented.

Recommendations:
The Contractor must create policies and procedures regarding the timely loading of physician contracts and fee schedules.

General Administration

Standard
GA 4
The Contractor has periodic audit procedures in place to verify the accuracy of information loaded in the claims payment system. [Contract Section D, Paragraph 25]

Findings: PARTIAL COMPLIANCE
The Contractor has periodic audit procedures in place to verify the validity of information loaded in the claims payment system. (Contract information, current codes)

Documents Reviewed:
Phoenix Rehab Manager Contract Code Matrix
Table Maintenance Matrix

Comments:
The presented documentation did not support that the Flagstaff, Yuma and Tucson clinics audit claim payment systems for the accuracy or completeness of loaded information.

Recommendations:
The Contractor must implement and enforce uniform auditing policy to ensure claim payment systems are correctly populated.

General Administration

Standard
GA 5
The Contractor provides training to all staff members on AHCCCS program guidelines.
[Contract Section D, Paragraph 11]

Findings: PARTIAL COMPLIANCE
The Contractor does not provide training to all staff members on AHCCCS program guidelines.

Documents Reviewed:
Fraud and Abuse training presentation
Fraud and Abuse training attendance
Secure Messenger training presentation
Secure Messenger training attendance

Comments:
The Contractor is in the process of developing a standardized training curriculum. CRSA was able to present evidence of large group educational meetings and informational e-mail communication from the previous contract year. However, no formalized schedule or curriculum was presented.

Recommendations:
The Contractor should finalize and implement a standardized New Employee Orientation for all employees at the Administration and Clinic level.

General Administration

Standard:
GA6
The Contractor meets minimum AHCCCS staffing requirements.
[Contract Section D, Paragraph 10]

Findings: FULL COMPLIANCE
The Contractor meets minimum AHCCCS staffing requirements.

The Contractor has adequate staffing in place to perform oversight of the subcontractors including assessing the quality of recipient services and care, and the ability of the subcontractors to perform subcontracted activities or to perform functions delegated through subcontractual agreements.

Documents Reviewed:
Org Chart
Mapping list from Contract language to Org Chart

Comments:
None

Recommendations:
None

General Administration

Standard:
GA7
The Contractor notifies AHCCCS of key personnel changes.
[Contract Section D, Paragraph 10]

Findings: FULL COMPLIANCE
The Contractor notifies AHCCCS of key personnel changes.

Documents Reviewed:
Examples of notification letters submitted to AHCCCS

Comments:
None

Recommendations:
None

General Administration

Standard:
GA8
The Contractor provides copies of the AMPM to each Regional Clinic and shares AMPM updates with each Regional Clinic. [Contract Section D, Paragraph 4]

Findings: FULL COMPLIANCE
CRSA provides copies of the AMPM to each Regional Clinic.

Documents Reviewed:
Agenda for Medical Director/Administration Meetings
Notification Emails to Contractors

Comments:
None

Recommendations:
None

General Administration

Standard:
GA9
The Contractor maintains a policy on policy development, review and approval.
[Contract Section D, Paragraph 11]

Findings: FULL COMPLIANCE
The Contractor maintains a policy on policy development, review and approval.

The Contractor adheres to its policy on policy development, review and approval.

Documents Reviewed:
Policy GA 1.4 approved 2/23/07

Comments:
The Contractor presented a matrix of policies that had been reviewed under the new Policy. However, it was unclear how frequently the Contractor plans to review each policy as currently the focus is on ensuring that adequate policies are in place for each operational area.

Recommendations:
The Contractor should consider adding a frequency table to its policy on policy development.

General Administration

Standard:
GA10
The Contractor's websites include the formulary, policies and procedures, recipient handbook and provider listing. [Contract Section D, Paragraph 152]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor and Clinic websites include the formulary, policies and procedures, recipient handbook and provider listings.

Documents Reviewed:
Tool for Website Review
Completed February 2007 Review

Comments:
It is evident that the Contractor has recently implemented a process for the oversight of the clinic websites. Based on review of the February evaluations, it is also clear that the contractor has identified deficiencies in the Tucson website that require correction.

Recommendations:
Tucson website should include the formulary, policies and procedures, recipient handbook and provider listings.

General Administration

Standard
CC 1
The Contractor has a mandatory compliance plan that is designed to guard against fraud and abuse.
[Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: FULL COMPLIANCE
The Contractor has a mandatory compliance plan that is designed to guard against fraud and abuse.

Documents Reviewed:
February 2007 update of ADHS Compliance Plan

Comments:
CRSA has been included in the ADHS Compliance Plan for the current year and has begun training employees on the program as of March 2007. This plan was developed for a separate agency that operates under the same compliance guidelines and is universally adaptable.

Recommendations:
None

General Administration

Standard
CC 2
The Contractor compliance mechanism is supported by written policies, procedures and standards of conduct that demonstrate a commitment to comply with all applicable Federal and State standards.
[Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: FULL COMPLIANCE
The Contractor compliance mechanism is supported by written policies, procedures and standards of conduct that demonstrate a commitment to comply with all applicable Federal and State standards.

Documents Reviewed:
Fraud and Abuse Unit Operations Manual
CRSA Policies and Procedures for 2006

Comments:
None

Recommendations:
None

General Administration

Standard
CC 3
The Contractor has policies and procedures for the referral of suspected fraud or abuse within ten days of discovery. [Contract Section D, Paragraph 51; 42 CFR 455.1]

Findings: FULL COMPLIANCE
The Contractor has policies and procedures for the referral of suspected fraud or abuse within ten days of discovery

Documents Reviewed:
ADHS Policies and Procedures
OCSHCN Website
CRSA Policy

Comments:
None

Recommendations:
None

General Administration

Standard
CC 4
The Contractor has evidence of Compliance training and education across all levels of the organization.
[Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has evidence of Compliance training and education across all levels of the organization.

Documents Reviewed:
Training Element on Compliance Officer
Fraud and Abuse Training Policy
Log of Training Attendance

Comments:
The Contractor is still in the process of implementation for this program. It is evident that a sampling of current employees has had an opportunity to attend training as of this review. However, the fact that a curriculum for new employee orientation was not complete during the review and has certainly not yet been implemented keeps this finding below full compliance.

Recommendations:
The Contractor should include Compliance training in the final standardized orientation program and require annual refreshing for all employees to ensure full agency training within one calendar year.

General Administration

Standard
CC 5
Contractor policy contains enforceable compliance standards with well-publicized disciplinary guidelines.
[Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: FULL COMPLIANCE
Contractor policy contains enforceable compliance standards with well-publicized disciplinary guidelines.

Documents Reviewed:
Training Element on Compliance Officer
ADHS Policies and Procedures
OCSHCN Website
CRSA Policy

Comments:
None

Recommendations:
None

General Administration

Standard
CC 6
The Contractor has a designated Compliance Officer that reports solely to executive management and is supported by a job description that outlines the responsibilities and the authority of the position.
[Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: FULL COMPLIANCE
The Contractor has a designated Compliance Officer that reports solely to executive management and is supported by a job description that outlines the responsibilities and the authority of the position.

Documents Reviewed:
Fraud and Abuse Manager Policy
Corporate Compliance Plan
Org Chart

Comments:
The Contractor participates in the ADHS Compliance program and has both a Corporate Compliance and Contract Compliance Officer that report findings to the CRSA Administrator.

Recommendations:
None

General Administration

Standard
CC 7
The Compliance Officer is empowered to access records and independently refer suspected fraud and abuse cases to AHCCCS OPI or other duly authorized enforcement agencies.
[Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: FULL COMPLIANCE
The Compliance Officer is empowered to access records and independently refer suspected fraud and abuse cases to AHCCCS OPI or other duly authorized enforcement agencies.

Documents Reviewed:
Corporate Compliance Plan

Comments:
The Contractor allows for any employee or subcontractor to directly report all fraud and abuse cases to AHCCCS OPI. Additionally, the Compliance Officer is responsible for proactive identification of fraud and/or abuse within the system at all levels.

Recommendations:
None

General Administration

Standard
CC 8
There are clear and confidential channels of communication between the contractor's employees and the Compliance Officer. [Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: SUBSTANTIAL COMPLIANCE
There are clear and confidential channels of communication between the contractor employees and the Compliance Officer.

Documents Reviewed:
Corporate Compliance Plan

Comments:
No statements of the availability and confidentiality of employee communications are found within the training materials.

Recommendations:
The Contractor employee training materials should include language that all employees have direct access to a confidential compliance reporting mechanism.

General Administration

Standard
CC 9
The Contractor has evidence of the Compliance Officer review of cases for appropriate referral to Office of Program Integrity (OPI). [Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: NON COMPLIANCE
The Contractor does not have evidence of compliance officer review of cases for appropriate referral to Office of Program Integrity (OPI).

Documents Reviewed:
Corporate Compliance Plan
Interview response from Compliance Officer
Matrix of Fraud and Abuse Referrals

Comments:
The Contractor's mechanism for reporting does not ensure cases referred AHCCCS OPI are reviewed by the Corporate Compliance Officer for the tracking and trending of issues; the reduction inappropriate referral and the identification of training opportunities within the Contractor.

Recommendations:
The Compliance Officer must review of fraud and abuse cases for appropriate referral to Office of Program Integrity (OPI).

General Administration

Standard
CC 10
The Contractor has a designated Compliance Committee that consists of the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources.
[Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: FULL COMPLIANCE
The Contractor has a designated Compliance Committee that consists of the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources.

Documents Reviewed:
Corporate Compliance Plan

Comments:
None

Recommendations:
None

General Administration

Standard
CC 11
The Compliance Committee has performed a review of the effectiveness of the compliance program and the timeliness of compliance reporting. [Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: NON COMPLIANCE
The Compliance Committee has not performed a review of the effectiveness of the compliance program and the timeliness of compliance reporting.

Documents Reviewed:
Corporate Compliance Plan
Corporate Compliance Committee Meeting Minutes

Comments:
Since the Contractor has only recently been included in the ADHS Compliance program, review of the effectiveness and reporting have been planned but not yet initiated as of this review.

Recommendations:
The Contractor must review the effectiveness of the compliance program and timeliness of compliance reporting within the current contract year.

General Administration

Standard
CC 12
The Contractor has a policy and procedure for the auditing of claims payment information to identify inconsistencies and potential fraud. [Contract Section D, Paragraph 51; 42 CFR 438.608]

Findings: FULL COMPLIANCE
The Contractor has a policy and procedure for the auditing of claims payment information to identify inconsistencies and potential fraud.

Documents Reviewed:
Corporate Compliance Plan
Audit and Review Policy and Procedures
Field Audit Program
Sample Audit Report

Comments:
While the Contractor has only just begun to implement the policy and procedure, data is not currently available but the processes are in place and are based on sound auditing principles.

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Authorization and Denial/Grievance System

AHCCCS REVIEW TEAM:	Kate Aurelius, Assistant Director Rodd Mas, Manager, Acute Care Operations Gina Aker, Operations & Compliance Officer Maureen Wade, Manager, Medical Management Debbie Reichow, Specialist, Medical Management Gerri Topolosek, Specialist, Medical Management Linda Vrabel, Specialist, Medical Management Joseph Ruiz, Hearing Officer III
CONTRACTOR STAFF:	Joan Agostinelli, Administrator Ashraf Lasee, Chief, UM/MM Stephen Burroughs, Chief, Quality Management Margery Sheridan, Chief, Consumer Rights Jennifer Vehonsky, Division Chief, Compliance
DATE OF REVIEW:	**March 12 through March 16, 2007**

Authorization and Denial/Grievance System

Standard
GS 1
The Contractor has a structure and process in place for the review of prior authorization requests. [CYE 07 contract, AMPM Chapter 1000, 42CFR438.201, 42 CFR 422.113 (c) and 42 CFR 438.114]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has a structure in place to process prior authorization requests.

The Contractor has a policy in place that identifies what services require prior authorization and a demonstrated process for communicating this with providers.

The Contractor does not utilize standardized criteria when making prior authorization decisions.

The Contractor does not require prior authorization for emergency services.

The Contractor does not ensure that any decision to deny, reduce or terminate a medical service is made by a qualified health care professional who has the expertise to make the decision.

The Contractor consults with the requesting provider when appropriate.

In __1___ out of _____1____ (_100__%) of files reviewed, the denial decisions were not made by the qualified health care professional and the rationale for the decision is clearly indicated and consistent with all BBA standards.

Documents Reviewed:
Medical Management/Utilization Management (MM/UM) 1.6 Prior Authorization Process
Chapter 80 Program Oversight, subsection 80.401 Prior Authorization (draft)
29 Denial Files
One (1) Notice of Action

Authorization and Denial/Grievance System

Comments:
The Contractor has been on a weekly oversight review of all Notices of Action (165) since November 16, 2006. On February 27, 2007, the Contractor was asked to not submit any Notices of Action for weekly review and submit Notices at the time of the OFR. The findings reported above represent the review of Notices of Action since February 27, 2007.

The Contractor utilizes InterQual in making service authorization determinations which is not all inclusive. The oversight MM/UM Activity titled "Prior Authorization" states that adverse decisions shall only be rendered by the CRS Regional Medical Director, who must sign all denials. During the interview, the Contractor did acknowledge that they did have knowledge of one regional clinic in which an RN signed a denial.

Recommendation:
The Contractor should continue with regional site reviews and audit all service request denials on a bi-monthly submission from the providers. The Contractor should develop a process to assure all denials are signed by a Medical Director.

Authorization and Denial/Grievance System

Standard
GS 2
The Contractor provides the member with a written notice of action in an easily understood format.
[Contract, Attachment H (1), H (2); ARS 36-2903.01(B) (4); AAC Title 9 Chapter 34; 42 CFR 438.10, 42 CFR 438.404, 42 CFR 438.406, 42 CFR 438.408, 42 CFR 438.410, 42 CFR 456.136]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor provides the member with a written notice of action in an easily understood language that states what is being denied, reduced or terminated and the reason and basis for the action.

Documents Reviewed:
29 Denial Files
One (1) Notice of action
Chapter 80 Program Oversight, subsection 80.402 Notice of Action (draft)
Chapter 80 Program Oversight Attachment 5-Notice of Action template

Comments:
The Contractor has been on a weekly oversight review of all Notices of Action (165) since November 16, 2006. Since November 16, 2006, weekly review of Notices of Action, the Contractor has not provided oversight for regional clinics. There was no standardized tool for oversight by the Contractor. The Contractor does not document the Notices of Action being in easily understood language.

The Contractor did provide a template for oversight of review of Notices of Action on January 31, 2007 which was accepted.

On February 27, 2007, the Contractor was asked to not submit any Notices of Action for weekly review and submit Notices at the time of the OFR.

Authorization and Denial/Grievance System

The Contractor provides a Notice of Action in both English and Spanish. One Notice of Action was in easily understood language.

Recommendations:
The Contractor must continue with regional site reviews and audit all service request denials on a bi-monthly submission from the providers. The Contractor should provide oversight tools and corrective action plans for all regional clinics on a bi-monthly submission.

Authorization and Denial/Grievance System

Standard
GS 3
The Contractor provides the member with a written notice that explains member rights.
[Contract, Attachment H (1), H (2); ARS 36-2903.01(B) (4); AAC Title 9 Chapter 34, 42 CFR 438.10, 42 CFR 438.404, 42, 42 CFR 438.408, 42 CFR 456.136]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor provides the member with a written notice that explains the:

- ✓ Member's right to file an appeal.
- ✓ Procedures for filing an appeal, requesting a state fair hearing, and expedited appeals
- ✓ Availability of assistance from the Contractor to file an appeal.

The Contractor's written notice explains the member's right to have services continue, how to request continued services, and when a member may be required to pay for the costs.

The Contractor's written notice explains to the member the correct Contractor timeframes required in making the decision.

Documents Reviewed:
29 Denial Files
Chapter 80 Program Oversight, subsection 80.402 Notice of Action (draft)
Chapter 80 Program Oversight Attachment 5-Notice of Action template
One (1) Notice of Action

Comments:
The Contractor has been on a weekly oversight review of all Notices of Action (165) since November 16, 2006. Since November 16, 2006, weekly review of Notices of Action, the Contractor has not provided oversight for regional clinics. There was no standardized tool for oversight by the Contractor.

Authorization and Denial/Grievance System

The Contractor did provide a template for oversight of review of Notices of Action on January 31, 2007 which was accepted.

On February 27, 2007, the Contractor was asked to not submit any Notices of Action for weekly review and submit Notices at the time of the OFR.

The Contractor demonstrated a template that explains the member's rights to appeal, procedures for filing an appeal, have services continue and how to request continued services.

Recommendations:
The Contractor must continue with regional site reviews and audit all service request denials on a bi-monthly submission from the providers. The Contractor should provide oversight tools and corrective action plans for all regional clinics on a bi-monthly submission.

Authorization and Denial/Grievance System

Standard
GS 4
The Contractor makes prior authorization decisions within 14 days for a standard request and within 3 days for an urgent (expedited) request and notifies the appropriate parties (requesting provider and member) of the outcome of the decision. [Contract, Attachment H (1), H (2); ARS 36-2903.01(B) (4); AAC Title 9 Chapter 34, 42 CFR 438.10, 42 CFR 438.404, 42 CFR 438.406, 42 CFR 438.408, 42 CFR 438.410, 42 CFR 456.136]

Findings: PARTIAL COMPLIANCE
The Contractor monitors the timeliness of all prior authorization decisions and acts upon any areas requiring improvement.

The Contractor notifies the appropriate parties (both member and requesting provider) of the outcome of the decision in accordance with the 3 day or 14 day standard.

The Contractor does not notify the requesting provider when an “expedited” authorization request does not meet the criteria for expedited authorization.

The Contractor does not document when an “expedited request” is determined to be a standard authorization to clearly indicate that the decision will be made within the fourteen (14) day timeframe.

The Contractor provides the member with written notice outlining the timeframes for expedited authorization decisions.

The Contractor does not provide member and provider the outcomes of the decisions (either positive or negative) within 3 days after an expedited request for a service is received.

Authorization and Denial/Grievance System

Documents Reviewed:
Chapter 80 Program Oversight, subsection 80.401 Prior Authorization (draft)
29 Denial files (2 expedited requests)

Comments:
One of two expedited requests was compliant with 3 day timeline. The other "expedited" authorization did not meet the BBA criteria for expedited, and was handled by the subcontractor as standard, but the subcontractor did not document the decision to handle as standard, or notify the member or provider that it would be handled as standard.

Recommendations:
The Contractor must develop a process for monitoring timeliness of prior authorization to include point of entry to ensure decision timeframes.

Authorization and Denial/Grievance System

Standard
GS 5
The Contractor issues an Extension Notice letter to the member when either the member requests an extension in making a service authorization decision, or if the Contractor requires further information in order to make a decision, up to 14 additional days (total of 28 days). The Contractor provides the member written notice of the reason for the decision to extend the time frame. [Contract, Attachment H (1), H (2); ARS 36-2903.01(B) (4); AAC Title 9 Chapter 34, 42 CFR 438.10, 42 CFR 438.404, 42 CFR 438.408, 42 CFR 456.136, 42 CFR 438.406, 42 CFR 438.410, A.R.S. 36-2903.01 (B) (4); and A.A.C. R-9-34-206 (D)]

Findings: PARTIAL COMPLIANCE
The Contractor provides the member with written notice that includes the timeframes by which the decision process will be extended**.**

The Contractor's written notice of the extension does include:
- ✓ The reason for the decision to extend the time frame
- ✓ The length of the extension
- ✓ The member's right to file a grievance (complaint) if the member disagrees with the decision.
- ✓ The decision will be made an expeditiously as the member's condition requires and no later than the date the extension expires.

The Contractor did not demonstrate using easily understood language in the template portion of the Notice of Extension.

Documents Reviewed:
29 Denial Files

Comments:
In 29 denial files, Notice of Extension was utilized 13 times to members.

Authorization and Denial/Grievance System

During interview, the Contractor stated that they do not monitor Notice of Extension letters for those services that were ultimately approved; therefore no documentation was available to substantiate that the Contractor was meeting timelines.

Recommendations:
The Contractor must revise the template use easily understandable language. The completed template should be forwarded to AHCCCS for final approval.

The Contractor should develop a process for monitoring of notice of extension timelines in approved service authorization requests. It is recommended that the Contractor send 100% of Notice of Extension letters to AHCCCS on a bi-monthly basis.

Authorization and Denial/Grievance System

Standard
GS 6
For service authorization requests that have complete medical information required for prior authorization, decisions not reached within 14 days, shall be considered denied on the date that the time frame expires and the Contractor provides the member with written notice of the denial. The Contractor must provide Notice of Action letter to assure the member their appeal rights. If no information is received for service authorization requests that required an extension, the request is considered denied and a Notice of Action letter must be sent.
[Contract, Attachment H (1), H (2); ARS 36-2903.01(B) (4); AAC Title 9 Chapter 34, 42 CFR 438.10, 42 CFR 438.10(d) (1), 42 CFR 456.136]

Findings: PARTIAL COMPLIANCE
The Contractor does not provide the member with written notice that for service authorization decisions not reached within 14 days, the authorization shall be considered denied on the date that the time frame expires**.**

The Contractor does not provide the member with written notice that for service authorization decisions not reached within 28 days, the authorization shall be considered denied on the date that the time frame expires**.**

Documents Reviewed:
Chapter 80 Program Oversight, subsection 80.401 Prior Authorization (draft)
Member Handbook

Comments:
The Contractor did provide amended policy 80 by March 19, 2007 and changes were accepted. The Contractor was not able to demonstrate that the Notice of Action letter is being tracked and send when a time frame expires and there is no receipt of requested documentation required to make a decision. The Contractor did not provide any files for review.

Authorization and Denial/Grievance System

Recommendations:
The Contractor must develop process for monitoring timelines for prior authorization requests.

Authorization and Denial/Grievance System

Standard
GS 7
The Contractor must provide written notice on any adverse decision related to an inpatient continued stay. The member is provided a minimum notification of 2 working days of the adverse decision before the assigned continued stay authorization expires.
[ARS 36-2903.01(B) (4); AAC Title 9 Chapter 34, 42 CFR 438.10, 42 CFR 438.404, 42 CFR 456.136]

Findings: FULL COMPLIANCE
The Contractor notifies the following parties when denying a continued inpatient stay:

- ✓ The Hospital or Facility
- ✓ The attending physician
- ✓ The member or responsible party

The Contractor provides notification of the member when an inpatient stay will be denied and the member is still in the facility.

The Contractor demonstrated retrospective review of inpatient records. The Contractor refers the denial decisions to the acute care plan and the requesting provider

Documents Reviewed:
MM/UM 1.6 Concurrent Review Process
Chapter 80 Program Oversight, subsection 80.404 Decertification of Hospital Stay
4 Inpatient Denial Records (Retrospective Review)

Comments:
None

Authorization and Denial/Grievance System

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 8
The Contractor issues and carries out appeal decisions within required timeframes.
[Contract, Attachment C(1); ARS 36-2903.01(B)(4); AAC Title 9 Chapter 34, 42 CFR 438.10, 42 CFR 438.404, 42 CFR 438.406, 42 CFR 438.408, 42 CFR 438.410, 42 CFR 438.414, 42 CFR 456.136]

Findings: FULL COMPLIANCE
The Contractor ensures ensure that its Subcontractor issues the appeal decision as expeditiously as the recipient's health condition requires and no later than the date the extension expires.

The Contractor ensures ensure that its Subcontractor provides oral notification of the appeal resolution decision.

Documents Reviewed:
Member Policy 60.404, 60.405, 60.406
Member Appeal Logs
Case File Review Tool
5 standard appeal files

Comments:
(CYE06 OFR GS6)
All requested files were provided.

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 9
The Contractor provides a provider with written acknowledgement of receipt of a claim dispute.
[42 CFR 438.406(f); Contract Section D, paragraph 25; Attachment C(2)]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor ensures that its Subcontractor provides a provider with written acknowledgement of receipt of a claim dispute.

Documents Reviewed:
Claim Dispute Policy 50.503(2)
Claim Dispute Logs
Claim Dispute Review Tool
Sample Acknowledgement Letter
17 Claim Dispute files

Comments:
(CYE06 OFR GS11)
3 of 17 (Tucson #1, #2, #3) files reviewed did not indicate that an acknowledgement letter had been issued.

Recommendations:
The CRSA must ensure that all claim disputes are acknowledged within 5 days of receipt.

Authorization and Denial/Grievance System

Standard
GS 10
The Contractor has a process for communication and coordination when an appeal or claim dispute decision is reversed. [42 CFR 438.424; Contract Section D, paragraph 25; Attachment C(1) and C(2)]

Findings: FULL COMPLIANCE
Contractor ensures that its Subcontractor has a process for communication and coordination when an appeal or claim dispute decision is reversed.

The member appeal files document when a reversed decision is implemented.

The claim dispute files document when a payment has been issued, including applicable penalties.

Documents Reviewed:
Member Appeal Policy 60.609
Claim Dispute Policy 50.503(7)
5 standard appeal files
17 provider claim dispute files

Comments:
(CYE06 OFR GS12)
None

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 11
The Contractor ensures that the individuals who make decisions on grievances and appeals meet AHCCCS standards. [42 CFR 438.406(b); Contract Attachment C(2)]

Findings: FULL COMPLIANCE
The Contractor monitors Subcontractor to ensure that the individuals who make decisions on grievances and appeals meet AHCCCS standards.

The review of each appeal was documented on the case file review tool.

Documents Reviewed:
Case File Review Tool
5 standard appeal files
17 provider claim dispute files

Comments:
(CYE06 OFR GS13)
None

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 12
The Contractor ensures that the individuals who make decisions on grievances and appeals are appropriately qualified. [42 CFR 438.406(a); Contract Attachment C(1), C(2)]

Findings: FULL COMPLIANCE
The Contractor monitors its Subcontractor to ensure that the individuals who make decisions on grievances and appeals are appropriately qualified.

The case files documented the medical reviews conducted during the appeal review process.

Documents Reviewed:
Case File Review Tool
5 standard appeal files
17 provider claim dispute files

Comments:
(CYE06 OFR GS14)
None

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 13
The Contractor resolves claim disputes and mails written a Notice of Appeals Resolution no later than 30 days after receipt. [42 CFR 438.408(6)(1); Contract Attachment C(1)]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor resolve(s) claim disputes and mails written a Notice of Appeals Resolution no later than 30 days after receipt.

All claim dispute files reviewed had a copy of a written response to the claim dispute.

Documents Reviewed:
Claim Dispute Policy 50.503(3)
17 provider claim dispute files

Comments:
(CYE06 OFR GS15)
None

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 14
The Contractor has documentation of all extension agreements for disputes not resolved within 30 days from receipt. [Contract Attachment C(1),C(2)]

Findings: NOT APPLICABLE
The Contractor ensures that its Subcontractor (has) have documentation of all extension agreements for disputes not resolved within 30 days from receipt.

No extension requests were required during the review period.

Documents Reviewed:
Claim Dispute Policy 50.503
17 provider claim dispute files
Sample Extension Request

Comments:
(CYE06 OFR GS16)
None

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 15
The Contractor claim dispute Notice of Appeals Resolution includes all required information.
[42 CFR 438.408(e)]

Findings: NON COMPLIANCE
The Contractor does not ensure that its Subcontractor show(s) evidence that the claim dispute Notice of Appeals Resolution includes all required information.

Documents Reviewed:
Claim Dispute Policy 50.503(3)
17 provider claim dispute files
Training Logs
Sample Notice of Decision

Comments:
(CYE06 OFR GS17)
12 of 17 claim dispute files reviewed did not indicate the factual and legal basis for the decision.

Recommendations:
CRSA must ensure that all claim dispute Notice of Decision indicate the factual and legal basis for the decision.

Authorization and Denial/Grievance System

Standard
GS 16
The Contractor maintains claim dispute records.
[42 CFR 438.416]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor maintain(s) claim dispute records.

Documents Reviewed:
Claim Dispute Policy 50.503(6)
17 provider claim dispute files
Claim Dispute Logs

Comments:
(CYE06 OFR GS18)
All requested logs and files were provided for review.

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 17
The Contractor logs, registries, or other written records include all required information.
[42 CFR 438.416)]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor show(s) evidence that the logs, registries, or other written records include all required information.

Documents Reviewed:
Standards for Payment Policy, Chapter 50
Grievance System Policy, Chapter 60
Program Oversight Policy, Chapter 80
Appeal Logs
Claim Dispute Logs
5 standard appeal files
17 provider claim dispute files

Comments:
(CYE06 OFR GS19)
All requested logs and files were submitted. The CRSA has submitted their Quarterly Claim Dispute Report accurately.

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 18
The Contractor continues or reinstates the enrollee's benefits while the appeal is pending, when:

- **The recipient files the appeal timely;**
- **The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;**
- **The services were ordered by an authorized provider;**
- **The original period covered by the original authorization has not expired; and**
- **The recipient requests continuation of services.**

[42 CFR 438.420)]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor show(s) evidence that it continues or reinstates the recipient's benefits while the appeal is pending, when the above mentioned situations arise.

Documents Reviewed:
Member Appeal Policy 60.608
5 standard appeal files

Comments:
(CYE06 OFR GS21)
None

Recommendations:
None

Authorization and Denial/Grievance System

Standard
GS 19
If the Contractor or the Director's Decision reverses a decision to deny, limit, or delay services that were not furnished while an appeal, or hearing was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the recipient's health condition requires.
[42 CFR 438.424(a)(b)]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor ensures that its Subcontractor authorize(s) or provide the disputed services promptly, and as expeditiously as the member's health condition requires, when a reverse decision to deny, limit, or delay services that were not furnished while an appeal, or hearing was pending.

One appeal file reversed the previous decision to deny. That file (AP006 0928 01) did not indicate that an authorization was updated, or that services were provided.

Documents Reviewed:
Member Appeal Policy 60.609
5 standard appeal files

Comments:
(CYE06 OFR GS22)
None

Recommendations:
The CRSA must ensure that their Contractor documents any authorization or provision of service that is the result of an overturned denial.

Authorization and Denial/Grievance System

Standard:
GS20
The Contractor allows a provider with the recipient's written consent to file an appeal on behalf of the recipient.
[42 CFR 438.402(f); Contract Section D, paragraph 25; Attachment C(1), C(2)]

Findings: FULL COMPLIANCE
The Contractor ensures that its Subcontractor allow a provider with the recipient's written consent to file an appeal on behalf of the recipient.

The CRSA Provider Manual and Claim Dispute Policy specifically allows for a provider to appeal on behalf of a member.

Documents Reviewed:
Member Appeal Policy 60.40192)
Provider Manual
Notice of Action
5 standard appeal files

Comments:
(CYE06 OFR GS10)
None

Recommendations:
None

Authorization and Denial/Grievance System

Standard:
GS21
The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal. [42 CFR 438.410(b)]

Findings: FULL COMPLIANCE
The Contractor monitors its Subcontractor to ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

Documents Reviewed:
Member Appeal Policy 60.201(4)
5 standard appeal files

Comments:
(CYE06 OFR GS20)
None

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Medical Management

AHCCCS REVIEW TEAM:

Kate Aurelius, Assistant Director
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Gina Aker, Operations & Compliance Officer
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Debbie Reichow, Specialist, Medical Management
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Earlene Allen, UM Specialist
Michelle Reese, UM Specialist
M. Clements, M.D., Medical Director
Julie Kris, Research & Statistical Analyst

DATE OF REVIEW: **March 12, 2007-March 16, 2007**

Medical Management

Standard
MM 1
The Contractor has implemented procedures for utilization management program requirements, which are consistent with AHCCCS standards, provider monitoring and an evaluation of services.
[AMPM Chapter 1000; 42 CFR 438.240, 42 CFR 456.1, 42 CFR 456.3, 42 CFR 456.5]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has implemented processes for monitoring and evaluating utilization of services which the Plan has identified as variances (both over and under) in utilization patterns.

The Contractor assesses the quality of services provided when utilization data variances are present (over and under utilization).

The Contractor has criteria that outline the variance criteria that would identify members and providers who require intervention in order to correct misutilization patterns. (42 CFR 456.22 through 23)

The Contractor does not act on identified variances (high or low utilization).

The Contractor demonstrated monitoring and evaluation of service utilization. A review of the MM/UM Committee minutes and reports presented at the meetings revealed a commitment to trend identification, analysis of variances, and discussion of trend cause. The Contractor's comprehensive review of utilization data has been instituted within the last two (2) quarters. The Contractor has not had adequate time to evaluate any recently instituted interventions that have resulted from the recent data analysis. The evaluation of the efficacy of any planned interventions will need to be reported in future UM/MM meetings The Contractor has a plan for including the evaluation in their meetings and simply requires implementation of this process. The Contractor identifies the provider as the four regional clinics.

Medical Management

Documents Reviewed:
Medical Management/Utilization Management (MM/UM) 1.1 Detection of Under and Over Utilization Services
MM/UM 1.2 Children's Rehabilitative Services Administration (CRSA) Regional Contractors' Encounters Review
MM/UM 1.3 Drug Utilization Review
MM/UM 1.4 Monitoring Durable Medical Equipment
MM/UM Committee Meeting Minutes
Quarterly UM Data Reports for Fiscal Year (FY) 2007

Comments:
None

Recommendations:
The Contractor must evaluate the interventions planned as a result of trended data analysis.

Medical Management

Standard
MM 2
The Contractor reviews utilization data and reports trends, variances, analysis/ evaluation and interventions through the Medical Management Committee. The Contractor acts and follows through on committee recommendations.
[AMPM Chapter 1000; 42 CFR 438.240, 42 CFR 456.1, 42 CFR 456.3, 42 CFR 456.5]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has minutes from the committee meetings which reflect the following:

- ✓ Reporting of data over time reflecting any trends
- ✓ Addresses any untoward trends and minutes reflect analysis and plans for interventions

The Contractor does not report on the previous meetings recommendations, analyzes interventions and makes changes based on the recommendations.

The Contractor demonstrated consistent monitoring and evaluation of service utilization. A review of the MM/UM minutes and reports presented at the meetings revealed a commitment to trend identification, analysis of variances, and discussion of trend cause. The Contractor's comprehensive review of utilization data has been instituted within the last two (2) quarters. The Contractor has not had adequate time to evaluate any recently instituted interventions that have resulted from the recent data analysis. The evaluation of the efficacy of any planned interventions will need to be reported in future UM/MM meetings The Contractor has a plan for including the evaluation in their meetings and simply requires implementation of this process. The Contractor identifies the provider as the four regional clinics.

Documents Reviewed:
MM/UM Committee Meeting Minutes
CRS MM/UM Data Sub-Committee Meeting Minutes
Quarterly UM Data Reports for FY 2007

Medical Management

Readmissions within 30 days of Discharge Report
Emergency Room Visits by Site Report

Comments:
None

Recommendations:
The Contractor must evaluate the interventions planned as a result of trended data analysis.

Medical Management

Standard
MM 3
The Contractor identifies and intervenes on member or provider profiling data that demonstrates a variance.
[42 CFR 456.22-23]

Findings: FULL COMPLIANCE
The Contractor demonstrates the application of Contractor criteria for identification and intervention of over utilization of facility services made by a member.

The Contractor demonstrates the application of Contractor criteria for identification and intervention of over/under utilization of facility services made by a provider.

The Contractor refers any utilization issues to the Medical Management Committee, or appropriate committee for review.

The Contractor has a process for acting on any issues of authorization timeliness and the analysis of this on potential adverse member care.

The Contractor identifies the provider as the four regional clinics. The Contractor demonstrated consistent application of criteria in the identification and intervention of over and under utilization relative to both members and providers. The Contractor reported 4 regional site visit audits which were completed by12/20/06 with recommendations in meeting minutes.

Documents Reviewed:
MM/UM 1.4 Monitoring Durable Medical Equipment
MM/UM Committee Meeting Minutes

Comments:
None

Medical Management

Recommendations:
None

Medical Management

Standard
MM 4
Reserved

Medical Management

Standard
MM 5
The Contractor has implemented and monitors a comprehensive inter-rater reliability plan to ensure consistent application of criteria for clinical decision making.
[AMPM Chapter 1000; 42 CFR 438.236]

Findings: NON COMPLIANCE
The Contractor has written policies regarding inter-rater reliability for staff involved with the application of clinical criteria.

- ✓ Prior Authorization Staff
- ✓ Concurrent Review Staff
- ✓ Retrospective Review Staff
- ✓ Medical Director (s)

The Contractor does not evaluate the consistency with which individuals involved in clinical decision making apply standardized criteria and in accordance with any adopted practice guidelines.

- ____ Prior Authorization Staff
- ____ Concurrent Review Staff
- ____ Retrospective Review Staff
- ____ Medical Director (s)

The Contractor does not take action when staff does not demonstrate consistency in the authorization or approval/ denial of services.

The Contractor demonstrated a policy for Inter-Rater Reliability Testing but has not implemented Inter-Rater audits. The Contractor has scheduled Inter-rater training for April, 2007. The inter-rater training is specific to Inter-Qual. Inter-Qual criteria can be applied to acute care services but is not comprehensive of all of the service or authorization areas covered by the CRSA benefit, i.e. Durable Medical Equipment (DME).

Documents Reviewed:
Policy MM/UM 1.7 Inter-rater Reliability (IRR) Testing

Medical Management

Comments:
None

Recommendations:
The Contractor must implement and monitor all staff involved in the clinical review process to assure consistent application of the criteria used for decision making. The Contractor must assure the inter-rater reliability monitoring is comprehensive for all covered services that are included in prior authorization, concurrent and retrospective review.

Medical Management

Standard
MM 6
The Contractor has an effective concurrent review process, which includes a component for reviewing the medical necessity of inpatient stays. [CYE 07 Contract, AMPM Chapter 1000; 42 CFR 438.236 (a), (b), (c), 42 CFR 456]

Findings: FULL COMPLIANCE
The Contractor utilizes standardized criteria for length of stay determinations.

The Contractor has documented timeframes and frequencies for conducting Inpatient reviews.

The Contractor has policies that describe the relevant clinical information that is to be obtained when making hospital length of stay decisions or level of care determinations.

The Contractor ensures that any decision to authorize an inpatient stay for a duration or scope that is less than requested is made by a physician who has appropriate clinical expertise in treating the member's condition or disease.

The Contractor has a process for the oversight of the concurrent review process.

The Contractor delegates concurrent review process to regional contractors. During observation, the Contractor indicates that all 4 regional sites are using Interqual. The Phoenix regional clinic has implemented the use of Interqual effective January, 2007. All three concurrent review charts that were audited demonstrated a significant increase in documentation of severity and intensity of illness.

Documents Reviewed:
Chapter 80 Program Oversight, subsection 80.403 (draft)
MM/UM 1.6 Concurrent Review Process (draft)
Concurrent Review Process Monitoring Tool

Medical Management

Three (3) February 2007 concurrent review charts (Phoenix)

Comments:
None

Recommendations:
None

Medical Management

Standard
MM 7
The Contractor must conduct post delivery of services medical necessity reviews based on reasonable medical evidence or a consensus of relevant health care professionals. The Contractor does not deny payment for emergency services that have met the standards outlined by the BBA emergent care/ services regulation.
[AMPM Chapter 1000; 42 CFR 438.114]

Findings: PARTIAL COMPLIANCE
The Contractor denies payment for emergency services when the following criteria have been made:

The medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or with respect to a pregnant woman or her unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

The Contractor denies emergency services, when the emergency room provider, hospital, or fiscal agent has notified the member's Contractor within 10 calendar days of presentation for emergency services.

The Contractor denies payment for emergency services regardless of whether the entity that furnishes the service is contracted. **N/A**

The Contractor denies payment for emergency services or limit emergency services on the basis of a list of diagnoses or symptoms.

The Contractor denies post stabilization care services (provided under the definition of an emergency medical condition) in order to maintain the stabilized condition or to improve or resolve the patient's condition when:

Medical Management

1. Post-stabilization care services were not approved by the Contractor within one hour of a prior authorization requested by the treating provider or the Contractor could not be contacted for authorization.

2. The Contractor representative and the treating physician cannot reach agreement concerning the enrollee's care and the contracted physician is not available for consultation

The Contractor denies payment when the attending emergency physician has not determined that the member is sufficiently stabilized for transfer or discharge.

The Contractor does not have criteria describing what services require retrospective review, the time frames for the completion of such reviews, and the appropriate clinical staff involved in the reviews.

The Contractor documents the outcome of any retrospective review and the rationale for the decision by the appropriate clinical staff.

The Contractor does not report to the Medical Management or appropriate committee any identified utilization issues for analysis and intervention.

The Contractor does not have a policy for review and payment of emergency services as outlined by the BBA emergent care/services regulation.

Documents Reviewed:
MM/UM 1.2 CRS Regional Contractors' Encounters Review
Chapter 80 Program Oversight, subsection 80.405 (draft)
Member Handbook

Comments:
The Contractor does not have to pay for emergent services for CRSA covered conditions when care is provided in a non-contracted facility per AHCCCS contract as the primary AHCCCS Contracted health plan is responsible. The Contractor

is responsible for all CRSA covered conditions that present as emergent when the member is at a contracted facility. The Contractor does review all emergency room / emergent admissions to the hospital, but did not have any written guidelines for compliance with the BBA standards on emergent care and post-stabilization criteria that was applied in the review. There was no documentation in the Medical Management Meeting or Quality meeting minutes of a review of the findings of the findings, trends or analysis of the admissions and clinical findings of the audits.

Recommendations:
The Contractor must have a process for trending and analysis of their retrospective reviews. The Contractor must include in policy the guidelines for review of emergent services that comports with the BBA definition of emergent care. The Contractor cannot deny payment for services deemed emergent if the attending physician has not determined the member is stabilized.

Medical Management

Standard
MM 8
The Contractor adopts and disseminates practice guidelines that comply with all BBA requirements. The Contractor adopts and monitors provider compliance with national practice guidelines and/ or local standards of practice. [AMPM Chapter 1000; 42 CFR 438.236]

Findings: FULL COMPLIANCE
The Contractor has practice guidelines that comply with the following criteria:

- ✓ based on valid and reliable clinical evidence or a consensus of health care professionals in the field
- ✓ consider the needs of the Contractor's members
- ✓ are adopted in consultation with contracting health care professionals and / or National Practice standards (note: in the absence of national practice guidelines, the guidelines are developed in consultation with health care professionals and through a review of peer-reviewed articles in medical journals published in the United States.)

The Contractor demonstrates a process by which practice guidelines are disseminated to all affected providers and upon request to members, or potential members.

The Contractor annually evaluate the Practice Guidelines through a multi-disciplinary process to determine if the guidelines remain applicable, and represent the best and most current practice standards

The Contractor monitors regional contractors' process for dissemination and implementation of clinical Practice guidelines during annual administrative review. The Contractor demonstrates clinical guidelines for spina bifida, cystic fibrosis, neurofibromatosis, sickle cell disease, metabolic disorder and cleft palate.

Documents Reviewed:
MM/UM 1.10 CRSA Clinical Practice Guidelines Review
MM/UM Committee Meeting minutes
List of Practice Guidelines
Delegated Agreements

Medical Management

Comments:
None

Recommendations:
None

Medical Management

Standard
MM 9
The Contractor has adopted and implemented a policy for the evaluation of new technologies that complies with AHCCCS standards. [AMPM Chapter 1000]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has a policy for evaluating new technologies or the application of existing technology to a new clinical use that is inclusive of consideration of coverage decisions by Medicare intermediaries, carriers, and / or Medicare, Federal or State Medicaid coverage decisions.

The Contractor has implemented a process for review of new technology based on authorization requests that may be time dependant.

The Contractor has not documented compliance with the policy that reflects the decision process and the basis for the decision on coverage.

Documents Reviewed:
MM/UM 1.9 CRSA New Medical Technology Coverage
Chapter 80 Program Oversight, Subsection 80.412 (draft)
MM/UM Committee Meeting Minutes

Comments:
The Contractor's policy for evaluating new technologies does include a process for review of new technology based on time frames of service requests. In the MM/UM Committee Meeting Minutes of October 26, 2006, new medical technologies approval was to be presented at the Executive Management Committee on November 8, 2006. No minutes of the Executive Management Committee were documented.

Medical Management

Recommendations:
The Contractor should consider reporting in the Executive Management Committee any new medical technologies that were requested and the timeframes for decision so that any trends can be identified.

Medical Management

Standard
MM 10
Reserved

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Medical Management

AHCCCS REVIEW TEAM:

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Rodd Mas, Manager, Acute Care Operations
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Earlene Allen, UM Specialist
Michelle Reese, UM Specialist
M. Clements, M.D., Medical Director
Julie Kris, Research & Statistical Analyst

DATE OF REVIEW: **March 12, 2007-March 16, 2007**

Medical Management

Standard
MM 1
The Contractor has implemented procedures for utilization management program requirements, which are consistent with AHCCCS standards, provider monitoring and an evaluation of services.
[AMPM Chapter 1000; 42 CFR 438.240, 42 CFR 456.1, 42 CFR 456.3, 42 CFR 456.5]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has implemented processes for monitoring and evaluating utilization of services which the Plan has identified as variances (both over and under) in utilization patterns.

The Contractor assesses the quality of services provided when utilization data variances are present (over and under utilization).

The Contractor has criteria that outline the variance criteria that would identify members and providers who require intervention in order to correct misutilization patterns. (42 CFR 456.22 through 23)

The Contractor does not act on identified variances (high or low utilization).

The Contractor demonstrated monitoring and evaluation of service utilization. A review of the MM/UM Committee minutes and reports presented at the meetings revealed a commitment to trend identification, analysis of variances, and discussion of trend cause. The Contractor's comprehensive review of utilization data has been instituted within the last two (2) quarters. The Contractor has not had adequate time to evaluate any recently instituted interventions that have resulted from the recent data analysis. The evaluation of the efficacy of any planned interventions will need to be reported in future UM/MM meetings The Contractor has a plan for including the evaluation in their meetings and simply requires implementation of this process. The Contractor identifies the provider as the four regional clinics.

Medical Management

Documents Reviewed:
Medical Management/Utilization Management (MM/UM) 1.1 Detection of Under and Over Utilization Services
MM/UM 1.2 Children's Rehabilitative Services Administration (CRSA) Regional Contractors' Encounters Review
MM/UM 1.3 Drug Utilization Review
MM/UM 1.4 Monitoring Durable Medical Equipment
MM/UM Committee Meeting Minutes
Quarterly UM Data Reports for Fiscal Year (FY) 2007

Comments:
None

Recommendations:
The Contractor must evaluate the interventions planned as a result of trended data analysis.

Medical Management

Standard
MM 2
The Contractor reviews utilization data and reports trends, variances, analysis/ evaluation and interventions through the Medical Management Committee. The Contractor acts and follows through on committee recommendations.
[AMPM Chapter 1000; 42 CFR 438.240, 42 CFR 456.1, 42 CFR 456.3, 42 CFR 456.5]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has minutes from the committee meetings which reflect the following:

- ✓ Reporting of data over time reflecting any trends
- ✓ Addresses any untoward trends and minutes reflect analysis and plans for interventions

The Contractor does not report on the previous meetings recommendations, analyzes interventions and makes changes based on the recommendations.

The Contractor demonstrated consistent monitoring and evaluation of service utilization. A review of the MM/UM minutes and reports presented at the meetings revealed a commitment to trend identification, analysis of variances, and discussion of trend cause. The Contractor's comprehensive review of utilization data has been instituted within the last two (2) quarters. The Contractor has not had adequate time to evaluate any recently instituted interventions that have resulted from the recent data analysis. The evaluation of the efficacy of any planned interventions will need to be reported in future UM/MM meetings The Contractor has a plan for including the evaluation in their meetings and simply requires implementation of this process. The Contractor identifies the provider as the four regional clinics.

Documents Reviewed:
MM/UM Committee Meeting Minutes
CRS MM/UM Data Sub-Committee Meeting Minutes
Quarterly UM Data Reports for FY 2007

Medical Management

Readmissions within 30 days of Discharge Report
Emergency Room Visits by Site Report

Comments:
None

Recommendations:
The Contractor must evaluate the interventions planned as a result of trended data analysis.

Medical Management

Standard
MM 3
The Contractor identifies and intervenes on member or provider profiling data that demonstrates a variance.
[42 CFR 456.22-23]

Findings: FULL COMPLIANCE
The Contractor demonstrates the application of Contractor criteria for identification and intervention of over utilization of facility services made by a member.

The Contractor demonstrates the application of Contractor criteria for identification and intervention of over/under utilization of facility services made by a provider.

The Contractor refers any utilization issues to the Medical Management Committee, or appropriate committee for review.

The Contractor has a process for acting on any issues of authorization timeliness and the analysis of this on potential adverse member care.

The Contractor identifies the provider as the four regional clinics. The Contractor demonstrated consistent application of criteria in the identification and intervention of over and under utilization relative to both members and providers. The Contractor reported 4 regional site visit audits which were completed by12/20/06 with recommendations in meeting minutes.

Documents Reviewed:
MM/UM 1.4 Monitoring Durable Medical Equipment
MM/UM Committee Meeting Minutes

Comments:
None

Medical Management

Recommendations:
None

Medical Management

Standard
MM 4
Reserved

Medical Management

Standard
MM 5
The Contractor has implemented and monitors a comprehensive inter-rater reliability plan to ensure consistent application of criteria for clinical decision making.
[AMPM Chapter 1000; 42 CFR 438.236]

Findings: NON COMPLIANCE
The Contractor has written policies regarding inter-rater reliability for staff involved with the application of clinical criteria.

- ✓ Prior Authorization Staff
- ✓ Concurrent Review Staff
- ✓ Retrospective Review Staff
- ✓ Medical Director (s)

The Contractor does not evaluate the consistency with which individuals involved in clinical decision making apply standardized criteria and in accordance with any adopted practice guidelines.

- ____ Prior Authorization Staff
- ____ Concurrent Review Staff
- ____ Retrospective Review Staff
- ____ Medical Director (s)

The Contractor does not take action when staff does not demonstrate consistency in the authorization or approval/ denial of services.

The Contractor demonstrated a policy for Inter-Rater Reliability Testing but has not implemented Inter-Rater audits. The Contractor has scheduled Inter-rater training for April, 2007. The inter-rater training is specific to Inter-Qual. Inter-Qual criteria can be applied to acute care services but is not comprehensive of all of the service or authorization areas covered by the CRSA benefit, i.e. Durable Medical Equipment (DME).

Documents Reviewed:
Policy MM/UM 1.7 Inter-rater Reliability (IRR) Testing

Medical Management

Comments:
None

Recommendations:
The Contractor must implement and monitor all staff involved in the clinical review process to assure consistent application of the criteria used for decision making. The Contractor must assure the inter-rater reliability monitoring is comprehensive for all covered services that are included in prior authorization, concurrent and retrospective review.

Medical Management

Standard
MM 6
The Contractor has an effective concurrent review process, which includes a component for reviewing the medical necessity of inpatient stays. [CYE 07 Contract, AMPM Chapter 1000; 42 CFR 438.236 (a), (b), (c), 42 CFR 456]

Findings: FULL COMPLIANCE
The Contractor utilizes standardized criteria for length of stay determinations.

The Contractor has documented timeframes and frequencies for conducting Inpatient reviews.

The Contractor has policies that describe the relevant clinical information that is to be obtained when making hospital length of stay decisions or level of care determinations.

The Contractor ensures that any decision to authorize an inpatient stay for a duration or scope that is less than requested is made by a physician who has appropriate clinical expertise in treating the member's condition or disease.

The Contractor has a process for the oversight of the concurrent review process.

The Contractor delegates concurrent review process to regional contractors. During observation, the Contractor indicates that all 4 regional sites are using Interqual. The Phoenix regional clinic has implemented the use of Interqual effective January, 2007. All three concurrent review charts that were audited demonstrated a significant increase in documentation of severity and intensity of illness.

Documents Reviewed:
Chapter 80 Program Oversight, subsection 80.403 (draft)
MM/UM 1.6 Concurrent Review Process (draft)
Concurrent Review Process Monitoring Tool

Medical Management

Three (3) February 2007 concurrent review charts (Phoenix)

Comments:
None

Recommendations:
None

Medical Management

Standard
MM 7
The Contractor must conduct post delivery of services medical necessity reviews based on reasonable medical evidence or a consensus of relevant health care professionals. The Contractor does not deny payment for emergency services that have met the standards outlined by the BBA emergent care/ services regulation.
[AMPM Chapter 1000; 42 CFR 438.114]

Findings: PARTIAL COMPLIANCE
The Contractor denies payment for emergency services when the following criteria have been made:

The medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or with respect to a pregnant woman or her unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

The Contractor denies emergency services, when the emergency room provider, hospital, or fiscal agent has notified the member's Contractor within 10 calendar days of presentation for emergency services.

The Contractor denies payment for emergency services regardless of whether the entity that furnishes the service is contracted.

The Contractor denies payment for emergency services or limit emergency services on the basis of a list of diagnoses or symptoms.

The Contractor denies post stabilization care services (provided under the definition of an emergency medical condition) in order to maintain the stabilized condition or to improve or resolve the patient's condition when:

Medical Management

1. Post-stabilization care services were not approved by the Contractor within one hour of a prior authorization requested by the treating provider or the Contractor could not be contacted for authorization.

2. The Contractor representative and the treating physician cannot reach agreement concerning the enrollee's care and the contracted physician is not available for consultation

The Contractor denies payment when the attending emergency physician has not determined that the member is sufficiently stabilized for transfer or discharge.

The Contractor does not have criteria describing what services require retrospective review, the time frames for the completion of such reviews, and the appropriate clinical staff involved in the reviews.

The Contractor documents the outcome of any retrospective review and the rationale for the decision by the appropriate clinical staff.

The Contractor does not report to the Medical Management or appropriate committee any identified utilization issues for analysis and intervention.

The Contractor does not have a policy for review and payment of emergency services as outlined by the BBA emergent care/services regulation.

Documents Reviewed:
MM/UM 1.2 CRS Regional Contractors' Encounters Review
Chapter 80 Program Oversight, subsection 80.405 (draft)
Member Handbook

Comments:
None

Medical Management

Recommendations:
The Contractor must have a process for trending and analysis of their retrospective reviews.

Medical Management

Standard
MM 8
The Contractor adopts and disseminates practice guidelines that comply with all BBA requirements. The Contractor adopts and monitors provider compliance with national practice guidelines and/ or local standards of practice. [AMPM Chapter 1000; 42 CFR 438.236]

Findings: FULL COMPLIANCE
The Contractor has practice guidelines that comply with the following criteria:

- ✓ based on valid and reliable clinical evidence or a consensus of health care professionals in the field
- ✓ consider the needs of the Contractor's members
- ✓ are adopted in consultation with contracting health care professionals and / or National Practice standards (note: in the absence of national practice guidelines, the guidelines are developed in consultation with health care professionals and through a review of peer-reviewed articles in medical journals published in the United States.)

The Contractor demonstrates a process by which practice guidelines are disseminated to all affected providers and upon request to members, or potential members.

The Contractor annually evaluate the Practice Guidelines through a multi-disciplinary process to determine if the guidelines remain applicable, and represent the best and most current practice standards

The Contractor monitors regional contractors' process for dissemination and implementation of clinical Practice guidelines during annual administrative review. The Contractor demonstrates clinical guidelines for spina bifida, cystic fibrosis, neurofibromatosis, sickle cell disease, metabolic disorder and cleft palate.

Documents Reviewed:
MM/UM 1.10 CRSA Clinical Practice Guidelines Review
MM/UM Committee Meeting minutes
List of Practice Guidelines
Delegated Agreements

Medical Management

Comments:
None

Recommendations:
None

Medical Management

Standard
MM 9
The Contractor has adopted and implemented a policy for the evaluation of new technologies that complies with AHCCCS standards. [AMPM Chapter 1000]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has a policy for evaluating new technologies or the application of existing technology to a new clinical use that is inclusive of consideration of coverage decisions by Medicare intermediaries, carriers, and / or Medicare, Federal or State Medicaid coverage decisions.

The Contractor has implemented a process for review of new technology based on authorization requests that may be time dependant.

The Contractor has not documented compliance with the policy that reflects the decision process and the basis for the decision on coverage.

Documents Reviewed:
MM/UM 1.9 CRSA New Medical Technology Coverage
Chapter 80 Program Oversight, Subsection 80.412 (draft)
MM/UM Committee Meeting Minutes

Comments:
The Contractor's policy for evaluating new technologies does include a process for review of new technology based on time frames of service requests. In the MM/UM Committee Meeting Minutes of October 26, 2006, new medical technologies approval was to be presented at the Executive Management Committee on November 8, 2006. No minutes of the Executive Management Committee were documented.

Medical Management

Recommendations:
The Contractor should consider reporting in the Executive Management Committee any new medical technologies that were requested and the timeframes for decision so that any trends can be identified.

Medical Management

Standard
MM 10
Reserved

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Recipient Services

AHCCCS REVIEW TEAM:	Don McClanahan, Compliance & Operations Officer Rodd Mas, Manager, Acute Care Operations Kate Aurelius, Assistant Director Gina Aker, Compliance & Operations Officer Maureen Wade, Manager, Medical Management
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DATE OF REVIEW:	**March 12 through March 16, 2007**

Recipient Services

Standard
RS 1
All materials in the New Recipient Orientation Packet have been approved by the Contractor.
[Contract, Section D, Paragraph 8; ACOM CRS Recipient Information Policy; AAC R9-22-518; CFR 42 438.10]

Findings: FULL COMPLIANCE
All materials included in the New Recipient Orientation Information Packet have been approved by AHCCCS.

Documents Reviewed:
Regional Contractors Policies and Procedure Manual: 80.501
Approval letters
New Member Orientation Packet Checklist

Comments:
(CYE06 OFR RS1; CYE05 OFR RS1.1)
None

Recommendations:
None

Recipient Services

Standard
RS 2
All new recipients receive a complete New Recipient Orientation Packet within ten days of the enrollment date.
[Contract, Section D, Paragraph 9; ACOM CRS Recipient Information Policy; AAC R9-22-518; CFR 42 438.10]

Findings: FULL COMPLIANCE
All new recipients receive a complete New Recipient Orientation Packet within ten days of the Contractor's notification of assignment by AHCCCSA.

Documents Reviewed:
CRS Regional Contractors Policy and Procedures Manual: 80.501 "New Member Orientation Packet"
Administrative Review Tool
New Recipient Orientation Packet

Comments:
None

Recommendations:
None

Recipient Services

Standard
RS 3
Reserved

Recipient Services

Standard
RS 4
The New Recipient Orientation Packet includes the current Recipient Handbook. Annually recipients are noticed that they can receive the Recipient Handbook. [Contract, Section D, Paragraph 3; ACOM Member Information Policy; AAC R9-22-518; CFR 42 438.10]

Findings: SUBSTANTIAL COMPLIANCE

Documents Reviewed:
CRS Regional Contractors Policy and Procedure Manual: 80.5013B
CRS Member Handbook
New Member Orientation Packet Checklist
CRSA Administrative Review Tool 2007
New Member Orientation Packet

Comments:
The Contractor did not provide evidence of a current Recipient Handbook in the New Recipient Orientation Packet for the Yuma Clinic.
(CYE06 OFR RS2, RS4; CYE05 OFR RS1.2, 2.1)

Recommendations:
The Contractor should ensure that the New Recipient Orientation Packet includes the current Recipient Handbook.

Recipient Services

Standard
RS 5
The New Recipient Orientation Packet includes a comprehensive provider listing, current summary of the provider network, or a provider directory. [Contract, Section D, Paragraph 9; ACOM CRS Recipient Information Policy; AAC R9-22-518; CFR 42 438.10]

Findings: FULL COMPLIANCE
The New Recipient Orientation Packet includes a provider directory.

Documents Reviewed:
New Member Orientation Packet Checklist (Flagstaff, Yuma, Tucson and Phoenix)
CRS Contractors Policy and Procedure Manual Chapter 80
Providers by Regional Contractor
Summary of Provider Network
Orientation Packets from Flagstaff, Yuma, Tucson, and Phoenix

Comments:
(CYE06 OFR RS3; CYE05 OFR RS1.3)
None

Recommendations:
None

Recipient Services

Standard
RS 6
Reserved

Recipient Services

Standard:
RS 7

Recipient Services

Standard
RS 8
The Contractor ensures that the recipient's dignity and privacy are protected and the recipient is treated with respect. [ACOM CRS Recipient Information Policy; 42 CFR 438.100]

Findings: NON COMPLIANCE
The Contractor's employee orientation does not provide the staff with an initial training about the protection of the recipient's dignity and privacy and to ensure that the recipient is treated with respect.

The Contractor does not provide the staff with ongoing training about procedures designed to protect the recipient's privacy and dignity and to ensure the recipient is treated with respect.

The Contractor does not monitor staff to ensure that they understand and follow the procedures to ensure that the recipient's privacy and dignity are protected and the member is treated with respect.

Documents Reviewed:
HIPAA Privacy Member Letter
Family Centered Survey Tool 2006
Family Centered Satisfaction Results 2006
CRS Member Handbook
CRS Member Information Letter
CRS Provider Manual

Comments:
The Contractor does not provide evidence of a program or process which ensures that the recipient's dignity and privacy are protected and the recipient is treated with respect.

Recipient Services

Recommendations:
The Contractor must develop a process and policy for training staff to ensure that the recipient's dignity and privacy are protected and the recipient is treated with respect.

Recipient Services

Standard
RS 9
The Contractor's staff is trained to respond appropriately to member inquiries and grievances.
[Contract, Section D, Paragraph 11]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor staff and its Subcontractor staff receive an orientation about Contractor responsibility, including responding to enrollee grievances.

The Contractor staff and its Subcontractor staff receive ongoing training on a regular basis.

Individual Contractor staff and its Subcontractor staff are not monitored on a regular and periodic basis (real time telephone monitoring).

Documents Reviewed:
CRS Grievance Education Training
Limited English Proficiency Training
Secure Messenger Training
Fraud & Abuse Training

Comments:
The Contractor did not evidence that Contractor and Subcontractor staffs are monitored on a regular and periodic basis (real time telephone monitoring).

Recommendations:
The Contractor should develop a process to ensure Contractor and Subcontractor staffs are monitored on a regular and periodic basis.

Recipient Services

Standard
RS 10
The Contractor's staff appropriately identifies and documents all recipient grievances.
[Contract, Section D, Paragraph 11]

Findings: FULL COMPLIANCE
The Contractor and Subcontractor staff appropriately identifies and document all recipient grievances.

Documents Reviewed:
Quality of Care Allegations Database Research Form
E-Learning Module on Non-Quality of Care Grievances

Comments:
None

Recommendations:
None

Recipient Services

Standard
RS 11
The Contractor staff refers individual recipient inquiries and grievances to other units/departments, as appropriate. [Contract, Section D, Paragraph 11]

Findings: FULL COMPLIANCE
The Contractor staff and its Subcontractor staff appropriately inform other units/departments, as appropriate, of recipient inquiries and/or grievances that involve provider actions.

The Contractor and its Subcontractor staff refer quality of care issues to the Quality Management Department.

The Contractor staff and its Subcontractor staff inform the Corporate Compliance Department about recipient inquiries and/or grievances related to fraud and abuse.

Documents Reviewed:
CRSA Phone Log 7/06

Comments:
The Contractor presented evidence of a phone log that tracks recipient and provider calls/inquires. However, the Contractor does not appear to have a systematic process for tracking and trending individual recipient inquires to ensure they are being referred and acted upon as appropriate.

Recommendations:
The Contractor should consider developing a formal process for tracking the referral of recipient inquires and grievances to other units/departments as appropriate.

Recipient Services

Standard
RS 12
The Contractor tracks, analyzes and trends recipient inquiries and grievances.
[Contract, Section D, Paragraph 24]

Findings: FULL COMPLIANCE
The Contractor has a system to track all recipient grievances and inquiries.

The Contractor analyzes recipient grievances and inquiries for trends.

The Contractor requires its Subcontractor to implement corrective actions based on the trends identified from the grievance and inquiry information.

Documents Reviewed:
Regional Contractors Policy and Procedure Manual Chapter 60.700
Documentation of Flagstaff cases
Non-QOC Grievances/Complaints, Feb. – Jun 2006
QOC FY06 Summary
E-Learning QOC Module Training

Comments:
None

Recommendations:
None

Recipient Services

Standard
RS 13 For Information Only

The Contractor received a total of 29 grievances for the current CYE07 to date.

The top three categories of grievances were:

1. Availability, Accessibility & Adequacy
2. Member Rights/Respect and Caring
3. Denial, Decrease or Discontinuance of Covered Benefits

Documents Reviewed:
Self reported documentation

Comments:
None

Recommendations:
None

Recipient Services

Standard
RS 14
The Contractor has a policy and process that notifies affected recipients timely when a frequently utilized specialist leaves the network. [Contract, Section D, paragraph 19, ACOM CRS Recipient Information Policy, 42 CFR 438.10]

Findings: FULL COMPLIANCE
The Contractor follows a policy and process that notifies affected recipients timely when a frequently utilized specialist leaves the network.

Documents Reviewed:
Regional Contractors Policy and Procedure Manual Chapter 80
Regional Contractors Policy and Procedure Manual (CRS RCPPM) Section 10.207
Notification letters for Flagstaff, Phoenix and Tucson

Comments:
(CYE06 OFR RS6; CYE05 OFR RS5.1)
None

Recommendations:
None

Recipient Services

Standard
RS 15
The Contractor notifies affected recipients of significant program changes at least 30 days before the effective date of the change. [Contract, Section D, paragraph 9, ACOM Member Information Policy, 42 CFR 438.10]

Findings: FULL COMPLIANCE
The Contractor and its Subcontractor notify affected recipients of significant program changes at least 30 days prior to the effective date of the change.

Documents Reviewed:
Regional Contractors Policy and Procedure Manual Chapter 80
Approval letter for Regional Clinic Proposed Pharmacy Transition – Tucson notice to families of change

Comments:
(CYE06 OFR RS6; CYE05 OFR RS5.2)
None

Recommendations:
None

Recipient Services

Standard
RS 16 (For Information Only)
Contractor employees have access to references listing resources for recipients with diverse cultural needs.
[Contract, Section D, Paragraph 48; ACOM Cultural Competency Policy]

Findings:
The Contractor's and/or its Subcontractor's reference listings do include community resources available to meet recipients' diverse cultural needs.

Documents Reviewed:
Language Line Services Quick Reference Guide
OCSHCN Spanish Website
2006 Maricopa County – Arizona Directory of Human Services
OCSHCN Community Teams

Comments:
None

Recommendations:
None

Recipient Services

Standard
RS 17
The Contractor notifies AHCCCS Division of Health Care Management (DHCM), of the material change in the provider network 15 days prior to the provider notice being sent out.
[Contract, Section D, Paragraph 9, ACOM Member Information Policy, 42 CFR 438.10]

Findings: NON COMPLIANCE
The Contractor does not notify AHCCCS, Division of Health Care Management (DHCM), of the material change in the provider network 15 days prior to the provider notice being sent out.

Documents Reviewed:
Regional Contractors Policy & Procedure Manual, Chapter 10 – Adminstration
Regional Contractors Policy & Procedure Manual, Chapter 80 – Program Oversight

Comments:
Although the Contractor provided evidence of Subcontractor notification to Contractor of a material change in the provider network, there was no evidence of such notice to the AHCCCS Division of Health Care Management.

Recommendations:
The Contractor must ensure that AHCCCS DHCM is notified of a material change in the provider network 15 days prior to the provider notice being sent out.

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Quality Management

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DATE OF REVIEW: **March 12 through 16, 2007**

Quality Management

Standard:
QM1
The Contractor has the appropriate staff employed to carry out Quality Management Program administrative requirements. [AMPM, Chapter 900, policy 910, C5; 42 CFR 438.240 (a), (1)]

Findings: FULL COMPLIANCE
The Contractor employs sufficient Quality Management personnel to carry out the functions and responsibilities specified in Chapter 900 of the AMPM in a timely and knowledgeable manner.

Staff qualifications for education, experience and training are developed for each Quality Management Performance Improvement (QMPI) position.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
Organizational Chart
QM Standards Binders 1& 2

Comments:
None

Recommendations:
None

Quality Management

Standard:
QM2
The Contractor has a structure in place for a Quality Management Program that includes administrative requirements related to the peer review process.
[AMPM, Chapter 900, policy 910, C-4; 42 CFR 438.240; 42CFR 438.408; 42 CFR 438.414]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor's peer review process is clearly defined.

The Contractor's peer review process addresses the following components:

- ✓ Which cases are determined appropriate for peer review.
- ✓ Peer review is used to analyze and address clinical issues.
- ✓ Providers are made aware of the peer review process.
- ✓ Providers are made aware of the peer review grievance procedure.
- ✓ Peer review activities are carried out in a specific peer review committee or in executive sessions.
- ✓ At least one provider of the same or similar specialty under review does participate.

The Contractor has not yet implemented the formal Peer Review process.

The Contractor Peer Review policy indicates the Contractor Medical Director or designee can chair the Quality Management and Peer Review Committee.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
CRSA Peer Review Flow Chart

Quality Management

CRSA Peer Review Process QM 1.1 dated 02/01/2007
CRSA Peer Review Policy QM 1.1 CRSA Peer Review Committee Confidentiality and Conflict of Interest Agreement
Minutes for QM Committee Meetings 9/2 0/06, 10/24/06, 11/28/06, 12/19/06 and 2/01/07
CRSA Quality of Care Process QM 1.5
CRSA Children's Rehabilitative Services News dated February 2007
QM Standards Binders 1& 2

Comments:
None

Recommendations:
The Contractor must document implementation of a formal Peer Review process to be in compliance with AHCCCS requirements. The Contractor must clearly state in the Contractor Peer Review Policy that the Contractor Medical Director or his designated ADHS Medical Director will chair the Quality Management Committee and Peer Review Committee.

Quality Management

Standard:
QM3
The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for member/system resolution.
[AMPM, Chapter 900, Policy 960; 42 CFR 438.240; 42 CFR 438.402, 406, 408, and 416]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has been found to be 80% percent compliant with AMPM requirements after review of 15 quality-of-care files:

- ✓ The Contractor identifies the issue/problem
- ✓ Research process (log of events and conversations)
- ✓ The Contractor implements appropriate interventions to resolve the issue (from both a member and systems perspective)
- ✓ The Contractor communicates with the originator of the concern (opening and closing letter)

The Contractor does not communicate with the appropriate agencies (reports abuse, neglect and unexpected death to AHCCCS)

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
Randomly selected QOC charts
CRSA QM 1.5 CRSA Quality of Care Process
QM Standards Binders 1& 2

Comments:
The Quality of Care files reviewed included a case that should have been reported to the Pharmacy Board, but was done so only after AHCCCS advised the Contractor to report it. Of the files pulled for review, this was the only file in which the

issues should have been reported to another entity; therefore this finding cannot be reviewed for implementation based on documents reviewed.

The absence of an automated health information system makes it difficult to determine whether or not the Contractor is identifying the appropriate quality of care concerns.

Recommendations:
The Contractor must report issues to the appropriate agencies and regulatory bodies as stated in the AMPM, Chapter 900, Policy 960.

The Contractor must develop a process to identify all quality of care concerns from all potential sources.

The Contractor should consider standardizing QOC file structure to ensure completeness and accuracy.

The Contractor should consider utilizing the QOC Documentation-Data File monitoring tool to review the Contractor cases. The Contractor should develop a process for standardizing the QOC file structure including: dating and initialing entries made to the database; signing the database when the case is closed; checking the database entries to ensure that the case disposition and follow-up match; filling in the date that requested information was received and indicating if mail was returned by the post office.

The Contractor should consider entering the main and sub-allegations; provider and sub-provider into the database at the time the case is opened to assist with trending reports. There was no evidence that the Contractor has implemented a process to communicate concerns with appropriate agencies.

Quality Management

Standard:
QM4
The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for system improvement. [AMPM, Chapter 900, Policy 960; 42 CFR 438.240; 42 CFR 438.402, 406, 408, and 416]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor ensures quality-of-care complaints received anywhere in the organization are referred to Quality Management for investigation and resolution.

The Contractor incorporates successful interventions into the QM program or assign new interventions/approaches when necessary.

The Contractor does not monitor the success of interventions developed as a result of member complaint/abuse issues

The Contractor analyzes and evaluates the data from this system to determine any trends related to the quality of care in the Contractor's service delivery system or provider network.

The Contractor implements corrective action to reduce/eliminate the likelihood of complaints/abuse reoccurring

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
CRSA Quality of Care Process QM 1.5 Policy dated 3/06/2007
Quality of Care Database screens
Minutes for QM Committee Meetings 9/2 0/06, 10/24/06, 11/28/06, 12/19/06 and 2/01/07
QM Standards Binders 1& 2

Quality Management

Comments:
Even though the Contractors ensures quality of care concerns that are identified are referred to Quality Management, the absence of an automated health information system makes it difficult to determine whether or not the Contractor is identifying the appropriate quality of care concerns.

The Contractor issued corrective action to the Regional Contractors as a result of member complaints. The Contractor has not begun to monitor the success of interventions implemented by the Regional Contractors and intends to do this as part of their Annual Administrative Review Audit.

Recommendations:
The Contractor must develop a process to identify all quality of care concerns from all potential sources.

The Contractor must monitor the success of the interventions developed as a result of member complaint issues to be in compliance with AHCCCS requirements. The Contractor should consider an ongoing process, rather than relying solely on the Annual Administrative Review audit to evaluate the success of interventions.

Quality Management

Standard:
QM 5
The Contractor has a process in place for improving performance measure results.
[AMPM, Chapter 900, Policy 980, 8; 42 CFR 438.240]

Findings: NON COMPLIANCE
The Contractor is meeting the MPS for less than 50 percent of contractual Performance Measures (if so, score standard as Non-Compliance).

The Contractor's QM/PI Program conducts ongoing monitoring of its performance using standard performance measures and methodology established or adopted by AHCCCS.

The Contractor's QM/PI Program has a process to report its performance, internally and to AHCCCS, for standard performance measures established or adopted by AHCCCS at least annually.

The Contractor has a process to measure the success of interventions/activities implemented to improve performance measure rates.

Documents Reviewed:
QM Standards Binder #1, Tab 5
QM Binder List B, Tab 13
QM Committee Meeting Minutes for FY06

Comments:
Based on data provided by the Contractor for SFY 2006 and analyzed by AHCCCS, the Contractor is not meeting the minimum performance standard for any of the three contractual performance measures. Specifically, rates were:

Preliminary Determination of Medical Eligibility - 49.4% (MPS=75%)

Timeliness of Initial Evaluation - 67.8% (MPS=75%)
First Appointment with CRS Specialty Provider - 56.6% (MPS=75%)

A random audit of 35 charts from the Phoenix Regional Clinic for members included in the denominator for these measures, which was conducted by AHCCCS during the review, found data problems with 14 (40 percent) of these cases. In 13 cases, dates did not match between the chart and data file provided by the Contractor and other issues, such as specialty visits occurring prior to the application received by CRSA and data entry errors, were found. One record was missing.

The Contractor also has identified problems with internal data collection for these measures, and Regional Contractors have notified the Contractor that they believe there are major discrepancies in rates based on their own monitoring, compared with Contractor's analysis. Based on conversation with Contractor staff and observation of the data collection process at the Phoenix clinic, it is apparent that the Contractor is working to correct problems and standardize processes in an effort to improve the integrity of data for these performance measures. However, the Contractor has added exclusion criteria to the data collection methodology for "valid reasons" that a recipient did not have a specialist visit within 45 days of becoming enrolled in the program. This revision to the data collection methodology was not approved by AHCCCS before implementation.

The Contractor has required corrective action plans for Performance Measures from two Regional Contractors, Phoenix and Tucson. Results of internal monitoring for the first quarter of SFY 2007 show some improvement in rates for Preliminary Eligibility Determination. The Contractor is monitoring and trending results monthly by Regional Contractor; however, some sites have small numbers for each measure on a monthly basis, making it difficult to draw valid conclusions about their performance.

The Contractor staff state that it has begun looking at barriers to enrollment and accessing care, which may be affecting the Contractor's performance on these measures.

Recommendations:
The Contractor must continue to identify barriers and solutions to improving rates for contractual performance measures, in order to meet the AHCCCS Minimum Performance Standards.

Quality Management

Any deviations in data collection methodology, such as adding exclusion criteria, must be approved by AHCCCS and incorporated into the Contractor contract prior to implementation.

Quality Management

Standard:
QM6
The Contractor conducts Performance Improvement Projects (PIPs) to assess the quality and appropriateness of its service provision and to improve performance. [AMPM, Chapter 900, Policy 980, 1; 42 CFR 438.240]

Findings: FULL COMPLIANCE
The Contractor has:

- ✓ Evaluated the effectiveness interventions implemented under each PIP at least annually through its Quality Management Program structure.

- ✓ Implemented new, revised or enhanced interventions, based on its internal quality assessment and performance improvement process.

The Contractor has not conducted a formal remeasurement for either PIP that it currently has under way. However, it conducted an interim remeasurement of performance for its PIP on Improving Pediatric-to-Adult Transition Services. The interim measurement showed improvement from 0 percent in the baseline to a rate of 37 percent. CRSA has evaluated the findings from this interim measurement and used them to develop and conduct training sessions for Regional Contractors aimed at improving performance.

Documents Reviewed:
QM Standards Binder #1, Tabs 5&6
QM Binder List B, Tabs 13&14
QM Committee Meeting Minutes for FY06

Comments:
None

Quality Management

Recommendations:
None

Quality Management

Standard:
QM7
The Contractor has a process for verifying credentials of organizational providers. (Hospitals, nursing facilities, behavioral health residential treatment facilities, surgi-centers, etc.)
[AMPM, Chapter 900, Policy 950; 42 CFR 438.214] *(Not applicable if the Contractor has achieved accreditation.)*

Findings: PARTIAL COMPLIANCE
The Contractor validates the credentials of new organizational providers.

The Contractor re-validates the credentials of organizational providers every three years.

The Contractor does not validate that organizational providers are licensed to operate in the State.

The Contractor does not verify that organizational providers are compliant with other applicable State or Federal requirements.

The Contractor verifies that the organizational providers are reviewed and approved by an appropriate accreditation body or meets the Contractor's own standards.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
Minutes for QM Committee Meetings 9/2 0/06, 10/24/06, 11/28/06, 12/19/06 and 2/01/07
QM Standards Binders 1& 2
Delegated Agreements Standards Binder
Delegated Agreements Binder List B

Quality Management

Comments:
The organizational compliance indicators are on the Contractor's Regional Contractor Administrative Review Audit Tool, but the Regional Contractors have not yet been reviewed by the Contractor. The Annual Administrative Review of the Regional Contractors is necessary for the Contractor to be in compliance with AHCCCS standards.

Recommendations:
The Contractor must validate that Regional Contractors are licensed to operate in the State.

The Contractor must verify that organizational providers are compliant with other applicable State or Federal requirements.

Quality Management

Standard:
QM8

The Contractor has a structure in place for a Quality Management Program that includes administrative requirements for oversight and accountability for all functions and responsibilities described in AMPM Chapter 900 that are delegated to other entities.
[AMPM, Chapter 900, Policy 910, C-6; Policy 950, 3, 42CFR 438.240; 42 CFR 438.230]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor has submitted executed delegation contracts to AHCCCS for review.

The Contractor has a written agreement that specifies activities and report responsibilities designated to the subcontractor.

The Contractor ensures that a written agreement that provides for revoking delegation or imposing other remedies/sanctions if the subcontractor's performance is inadequate.

The Contractor does not evaluate the entity's ability to perform the delegated activities prior to delegation.

The delegated entity is not monitored on an ongoing basis and formally reviewed by the Contractor at least annually.

The Contractor ensures that the subcontractor takes corrective action if any deficiencies are identified.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
CRSA Administrative Review Tool 2007 for ADHS Regional Contractor
Minutes for QM Committee Meetings 9/2 0/06, 10/24/06, 11/28/06, 12/19/06 and 2/01/07

Quality Management

Delegated Agreements List B Binder
QOC Charts

Comments:
None

Recommendations:
A delegated entity must be monitored on an ongoing basis and formally reviewed by the Contractor at least annually to be in compliance with AHCCCS requirements.

The Contractor must ensure that the Regional Contractors accept and implement the Contractor's required corrective action if any deficiencies are identified.

Quality Management

Standard:
QM9
The Contractor ensures that each managed care member is guaranteed basic rights.
[AMPM, Chapter 900, Policy 930; 42 CFR 438.100, 438.10; 438.6; 42 CFR 431.51; 42 CFR 417.43]

Findings: FULL COMPLIANCE
The Contractor ensures that members have the right to:

- ✓ Participate in decisions regarding his or her health care, including the right to refuse treatment.
- ✓ Be free from any form of restraint or seclusion used a s a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- ✓ Be treated with respect and with due consideration for his or her dignity and privacy.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
CRS Member Handbook, online and hardcopy
CRS Provider Handbook

Comments:
None

Recommendations:
None

Quality Management

Standard:
QM10
The Contractor has a structure in place for a Quality Management Program that includes administrative requirements related to policy development. [AMPM, Chapter 900, Policy 910, C]

Findings: SUBSTANTIAL COMPLIANCE
The Contractor reviews/revises policies annually.

The Contractor does not ensure policies are approved and signed by the Contractor Medical Director (representing governing or policy-making body) and Executive Management.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
Policies:
QM 1.2 Performance Improvement Projects dated 3/1/07
Chapter 60 Grievance, Appeal, and Hearing dated 7/1/06
Policy GA 1.4 General Administration p. 1 of 1, 1) f): Submit document(s) to CRSA Executive Committee for approval and 2) Timeframe: CRSA's operational, fiscal, program, and administrative policies and procedures, are reviewed annually, or more frequently, based on new requirements or changes to existing requirements.
Policies signed by Medical Director: GA 1.1 Administrative Review Process, GA 1.5, How Information is disseminated through CRSA and CRS Regional Contractors Website, MM.UM1.1 through 1.10, QM 1.1 through QM 1.4. QM 1.5 in progress.
Chapter 60 Grievance, Appeal, and Hearing dated 7/1/06

Quality Management

Comments:
All of the policies reviewed included the signature of the Administrator, however not all of the policies included the signature of the Medical Director.

Recommendations:
The Contractor must ensure policies are approved and signed by the Contractor Medical Director (representing governing or policy-making body) as well as Executive Management.

Quality Management

Standard:
QM11
The Contractor ensures credentialing, re-credentialing and provisional credentialing of the providers in their contracted provider network. [AMPM Chapter 900, Policy 950; 42 CFR 438.214]

Findings: PARTIAL COMPLIANCE
The Contractor does not identify the Medical Director or designated physician as being responsible for oversight of the credentialing and re-credentialing and provisional decisions.

The Contractor does not identify the role of the credentialing committee.

Performance monitoring data is not included in the re-credentialing decision-making process for primary care practitioners. This must include at a minimum:

- Member concerns which include grievances (complaints) and appeals information,
- Information from identified adverse events,
- Utilization Management information,
- Risk Management information,
- Information on compliance with policies,
- Physician profiling,
- Performance Improvement and monitoring, and
- Contractor quality issues.

The Contractor developed a review tool for review of subcontractor's provisional, initial credentialing and re-credentialing of individual providers. The review tool includes the following two standards: The Contractor does/does not identify the Medical Director or designated physician as being responsible for oversight of the credentialing and re-credentialing and provisional decisions and the Contractor does/does not identify the role of the credentialing committee. However, only the provisional credentialing files reviewed at Flagstaff Medical Center were reviewed for compliance with these standards.

Quality Management

Utilization Management information, Risk Management information, information on compliance with policies, physician profiling, and performance improvement and monitoring were not areas addressed during the review.

__ of __ (___%) of the credentialing/re-credentialing files are compliant with the other AMPM requirements. (Not Applicable)

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
Credentialing review tool for CRSA Administrative Site Review for Flagstaff Clinic
Policy QM 1.4, Credentialing/Re-credentialing Policy

Comments:
None

Recommendations:
The Contractor must include all requirements of the AHCCCS AMPM Chapter 900, Policy 950 relating to the initial credentialing, re-credentialing and provisional credentialing of providers by Regional Contractors to be in compliance with AHCCCS requirements.

Quality Management

Standard:
QM12
The Contractor's credentialing/re-credentialing and provisional credentialing policies are reviewed and approved by the Contractor's Executive Management. [AMPM Chapter 900, Policy 950; 42 CFR 438.214]

Findings: FULL COMPLIANCE
The Contractor's credentialing/recredentialing and provisional credentialing policies are reviewed and approved by the Contractor's Executive Management.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
Policy QM 1.4

Comments:
None

Recommendations:
None

Quality Management

Standard:
QM13
The Contractor maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its QM/QI Program. [AMPM Chapter 900, Policy 910; 42 CFR 438.242, 42 CFR 438.240]

Findings: PARTIAL COMPLIANCE
The Contractor does not ensure that information/data received from providers is accurate, timely, and complete.

The Contractor does not review reported data for accuracy, completeness, logic, and consistency.

The Contractor's review and evaluation processes are not clearly documented.

Documents Reviewed:
Trend reports from QOC data base
Tracking Log (FTP file, data is entered manually)
Performance Measure data is collected manually

Comments:
The Contractor has many separate manual processes in place, however, the Contractor does not have a formal health information system. The Contractor does not have a formal process or system for validating that data collected is accurate, logical, timely and complete.

Recommendations:
The Contractor must develop a health information system to collect, integrate and analyze data. The health information system data must be validated for accuracy, timeliness, logic and completeness.

Quality Management

Standard:
QM14
The health information system data elements include at least the following information to guide the selection of and meet the data collection requirements for quality improvement requirements. [AMPM Chapter 900, Policy 910; 42 CFR 438.242, 42 CFR 438.240]

Findings: NON COMPLIANCE
The health information system does not include at least the following elements:
Member demographics
Services provided to members
Other information necessary for quality improvement (Grievances, utilization etc.)

Documents Reviewed:
Trend reports from QOC data base
Tracking Log (FTP file, data is entered manually)
Performance Measure data is collected manually

Comments:
The Contractor has many separate manual processes in place to collect data. Two of the Regional Contractors have implemented Rehab Manager which collects member demographics, and services provided. The Contractor does not have the ability to systematically track, trend, review etc. information on the programs as a whole.

Recommendations:
The Contractor must ensure all Regional Contractors have a health information data system. The Contractor must develop a process for integrating, analyzing and evaluating data from all Regional Contractors in order to develop accurate and appropriate quality improvement activities.

Quality Management

Standard:
QM15
The Contractor monitors that subcontracted clinics ensure providers maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures and/or receives medical/behavior health records from other providers who have seen the enrolled member. [AMPM Chapter 900, Policy 940; 42 CFR 438.208]

Findings: FULL COMPLIANCE
The Contractor monitors that subcontracted clinics ensure providers maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures and/or receives medical/behavior health records from other providers who have seen the enrolled member.

The Contractor monitors that subcontracted clinics confirm that the records are:
- ✓ Kept up-to-date
- ✓ Well organized
- ✓ Comprehensive with sufficient detail to promote effective patient care and quality review.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
CRS Provider Manual
CRSA QM Medical Record Documentation Monitoring Tool
QM Standards Binder 2 of 2, Chapter 70, Records

Comments:
None

Recommendations:
None

Quality Management

Standard:
QM16
The Contractor monitors that subcontracted clinics ensure providers maintain comprehensive records that incorporates at least the following components: [AMPM Chapter 900, Policy 940; 42 CFR 438.224]

Findings: FULL COMPLIANCE
The Contractor monitors that subcontracted clinics ensure providers maintain a comprehensive records that incorporates at least the following components:

- ✓ Member identification information on each page of the medical record. (i.e., name or AHCCCS identification number)
- ✓ Documentation of identifying demographics (i.e., the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative).
- ✓ Initial history of the member (i.e., family history, social history and preventive laboratory screening. The initial history for members under age 21 should also include prenatal care and birth history).
- ✓ Past medial history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
CRS Provider Manual
CRSA QM Medical Record Documentation Monitoring Tool
QM Standards Binder 2 of 2, Chapter 70, Records

Quality Management

Comments:
None

Recommendations:
None

Quality Management

Standard:
QM17
The Contractor monitors that subcontracted clinics ensure providers maintain a comprehensive records that incorporates at least the following components: [AMPM Chapter 900, Policy 940; 42 CFR 438.224]

Findings: FULL COMPLIANCE
The Contractor monitors that subcontracted clinics ensure providers maintain comprehensive records that incorporates at least the following components:

Dental history if available, and current dental needs and/or services. (if applicable)
Current problem list
Current medications
Documentation, initialed by the member's PCP to signify review of:

- Diagnostic information
  - Laboratory and radiology reports
  - Physical examination notes, and
  - Other pertinent data
- Reports from referrals, consultation and specialists
- Emergency/urgent care reports
- Hospital discharge summaries
- Behavioral health referrals and services provided, if applicable

Documentation related to:

- Advance directives
- Requests for release of information and subsequent release
- The transmittal of diagnostic, treatment and disposition information to the PCP and other providers as appropriate

Quality Management

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
CRS Provider Manual
CRSA QM Medical Record Documentation Monitoring Tool
CRSA Newsletter, February 2007
QM Standards Binder 2 of 2, Chapter 70, Records

Comments:
None

Recommendations:
None

Quality Management

Standard:
QM18
The Contractor monitors that subcontracted clinics ensure providers document in the member's medical record whether or not the adult member has been provided information on advance directives and whether an advance directive has been executed. [AMPM Chapter 900, Policy 940; 42 CFR 438.10]

Findings: FULL COMPLIANCE
The Contractor monitors that subcontracted clinics ensure providers document in the member's medical record notification of advance directives.

The Contractor monitors that subcontracted clinics ensure providers document in the member's medical record that an advance directive has been executed.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06
CRS Provider Manual
CRSA QM Medical Record Documentation Monitoring Tool

Comments:
None

Recommendations:
None

Quality Management

Standard:
QM19
The Contractor monitors that subcontracted clinics ensure that there is appropriate supervision by a licensed professional documented in the member's record. [AMPM Chapter 900, Policy 940; 42 CFR 438.214e]

Findings: FULL COMPLIANCE
The Contractor monitors that subcontracted clinics ensure that there is appropriate supervision by a licensed professional documented in the member's record.

The Contractor monitors that subcontracted clinics ensure that all member medical record information protected by Federal and State law is kept confidential.

Documents Reviewed:
Annual QM Plan CYE 07
Annual QM Evaluation CYE 06

Comments:
None

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Third Party Liability (TPL)

AHCCCS REVIEW TEAM:	Gina Aker, Operations & Compliance Officer Rodd Mas, Manager, Acute Care Operations
CONTRACTOR STAFF:	Jennifer Vehonsky, Division Chief, Compliance Jerri Gray, HIPAA Data Manager Cynthia Layne, Chief Financial Officer Joan Agostinelli, Administrator
DATE OF REVIEW:	**March 9 through March 12, 2006**

Third Party Liability (TPL)

Standard
TPL 1
The Contractor cost-avoids all claims and services that are subject to third-party payment.
[AAC R9-22-1001, 1009; Contract Section D, Paragraph 30]

Findings: FULL COMPLIANCE
The Contractor utilizes a formal process to identify claims and services that are subject to third-party payment.

The Contractor utilizes the AHCCCS Third Party Liability (TPL) leads file, containing verified third-party coverage information, to update the Contractor's cost avoidance information used to identify claims and services that are subject to third-party payment.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

Third Party Liability (TPL)

Standard
TPL 2
The Contractor reports all known changes in health insurance information, including Medicare, to AHCCCS Division of Member Services, no later than 10 days from the date of discovery.
[(AAC R9-22-1001, 1009; Contract Section D, Paragraph 30]

Findings: FULL COMPLIANCE
The Contractor reports known changes in health insurance information, including Medicare, to AHCCCS Division of Member Services, no later than 10 days from the date of discovery.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

Third Party Liability (TPL)

Standard
TPL 3
The Contractor immediately reports to AHCCCS the existence of any creditable health insurance for members eligible for KidsCare or Health Insurance Flexibility. [AAC R9-22-1001, 1009; Contract Section D, Paragraph 30]

Findings: FULL COMPLIANCE
The Contractor immediately reports to AHCCCS the existence of any creditable health insurance for members eligible for KidsCare.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

Third Party Liability (TPL)

Standard
TPL 4
The Contractor utilizes a formal process to identify claims and services that are subject to third-party payment, including the use of trauma code edits to identify claims and services that are subject to third-party payment.
[AAC R9-22-1001, 1009; Contract Section D, Paragraph 30]

Findings: FULL COMPLIANCE
The Contractor utilizes a formal process to identify claims and services that are subject to third-party payment.

The Contractor does not use trauma code edits, utilizing diagnostic codes 800 to 999.9 (excluding code 994.6) to identify claims and services that are subject to third-party payment. This Standard is not applicable to CRSA.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

Third Party Liability (TPL)

Standard
TPL 5
The Contractor refers all cases that involve the following circumstances to the AHCCCS authorized representative, and the Contractor does not pursue recovery on the case unless directed to do so by AHCCCS, or by the AHCCCS authorized representative:

- *** Uninsured/underinsured motorist insurance**
- *** First and third-party liability insurance**
- *** Tortfeasors, including casualty**
- *** Special Treatment Trusts**
- *** Restitution Recovery**
- *** Worker's Compensation**
- *** Estate Recovery**

[AAC R9-22-1001, 1009; Contract Section D, Paragraph 30]

Findings: FULL COMPLIANCE
The Contractor does always refer cases that involve the above mentioned circumstances to the authorized representative.

The Contractor does not pursue recovery on cases that involve the above mentioned circumstances unless they were authorized to do so by AHCCCS or by the AHCCCS authorized representative.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

Third Party Liability (TPL)

Standard
TPL 6
Reserved

Third Party Liability (TPL)

Standard
TPL 7
Reserved

Third Party Liability (TPL)

Standard
TPL 8
Reserved

Third Party Liability (TPL)

Standard
TPL 9
Reserved

Third Party Liability (TPL)

Standard
TPL 10
When the Contractor knows that a third party payer will not pay for a medically necessary service or will not pay as a result of timely filing limits, the Contractor does not require a provider to furnish a third party denial letter prior to making payment for the service. (AAC R9-22-1001, 1009; Contract Section D, Paragraph 30)

Findings: FULL COMPLIANCE
The Contractor ensures that its subcontractors do not require a provider to furnish a third party denial letter prior to paying the provider when CRSA or its subcontractors know that a medically necessary service/procedure will not be paid by a third party payer due to coverage limitations or as a result of non-timely filing limits.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

Third Party Liability (TPL)

Standard
TPL 11
If a third-party insurer (other than Medicare) requires the CRS recipient to pay any copayment, coinsurance or deductible, the Contractor makes these payments, even if the services are provided outside of the Contractor's network. (Contract Section D, Paragraph 30)

Findings: FULL COMPLIANCE
The Contractor and/or its Subcontractor pays copayment, coinsurance or deductible if a third-party insurer (other than Medicare) requires the CRS recipient to pay, even if the services are provided outside of the Subcontractor's network.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

Third Party Liability (TPL)

Standard
TPL 12
If the Contractor refers the recipient for services to a third-party insurer (other than Medicare), and the insurer requires payment in advance for all copayments, coinsurance and deductibles, the Contractor makes such payments in advance. (Contract Section D, Paragraph 30)

Findings: FULL COMPLIANCE
When the Contractor refers the recipient for services to a third-party insurer (other than Medicare), and the insurer requires payment in advance for all copayments, coinsurance and deductibles, the Contractor and/or its Subcontractor makes payments in advance.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

Third Party Liability (TPL)

Standard
TPL 13
In emergencies, the Contractor provides the necessary services and then coordinates payment with the third-party payer. The Contractor ensures that its cost avoidance efforts do not prevent a recipient from receiving such service and that the recipient is not required to pay any coinsurance or deductibles for use of the other insurer's providers. (42 CFR 438.106 and 438.114; Contract Section D, Paragraph 30)

Findings: FULL COMPLIANCE
In emergencies, the Contractor ensures that its Subcontractor provides the necessary services and then coordinates payment with the third-party payer.

The Contractor ensures that its Subcontractor's cost avoidance efforts do not prevent a recipient from receiving emergency services and that the recipient is not required to pay any coinsurance or deductibles for use of the other insurer's providers.

Documents Reviewed:
CRSA TPL Policy and Procedures
Regional Contractors TPL Policy and Procedures
Sample of closed cases

Comments:
None

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delegated Agreements

AHCCCS REVIEW TEAM:	Rodd Mas, Manager, Acute Care Operations Gina Aker, Operations & Compliance Officer Don McClanahan, Operations & Compliance Officer Maureen Wade, Manager, Medical Management Kate Aurelius, Assistant Director
CONTRACTOR STAFF:	M. Clement, M.D., Medical Director Margery Sheridan, Chief, Consumer Affairs Ashraf Lasee, Division Chief, Medical Management/Utilization Management Joan Agostinelli, Administrator Jennifer Vehonsky, Division Chief, Compliance Cynthia Lane, Chief Financial Officer Stephen Burroughs, Chief, Quality Management Judith Walker, Division Chief, Clinical Programs
DATE OF REVIEW:	**March 12 through March 16, 2007**

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delegated Agreements

Standard:
DA1
The Contractor has evidence of evaluating the prospective delegated entity's ability to perform the activities to be delegated before entering into a contract/written agreement with a delegated entity.
[42 CFR 438.230 (b)(1), CYE 06 Contract No. YH03-0032, Section D, Paragraph 39]

Findings: NOT APPLICABLE
The Contractor shows/does not show evidence of evaluating prospective delegated entities ability to perform the activities intended for delegation before entering into a contract/written agreement.

Documents Reviewed:
AHCCCS Subcontract Review Document
CRSA Provider Contracts
RFP Process Website Information

Comments:
(CYE06 OFR DA1)
The Contractor is in the last year of a four-year contracting cycle covering 7/1/03 through 6/30/07, the current contracts will be extended to contract year 7/1/07 through 6/30/08.

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delegated Agreements

Standard:
DA2
There is a contract/written agreement between the Contractor and the delegated entity that clearly defines the scope of responsibilities, including reporting, delegated under the contract/written agreement.
[42 CFR 438.230 (b)(2)(i), CYE 06 Contract No. YH03-0032, Section D, Paragraph 39]

Findings: FULL COMPLIANCE
The Contractor shows evidence written agreements with delegated entities that clearly identify the scope of responsibilities and reporting requirements.

Documents Reviewed:
Yuma Contract Amendment 7/1/06
Tucson Contract Amendment 7/1/06
Flagstaff Contract Amendment 7/1/06
Phoenix Contract Amendment 7/1/06

Comments:
(CYE06 OFR DA2)
None

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delegated Agreements

Standard:
DA3
The contract/written agreement provides for revoking delegation or imposing other sanctions if the delegated entity's performance is inadequate.
[42 CFR 438.230 (b)(2)(ii), CYE 06 Contract No. YH03-0032, Section D, Paragraph 39]

Findings: FULL COMPLIANCE
The Contractor's contract/written agreement with a delegated entity, provides for revoking of delegation or imposing other sanctions if the entities performance is inadequate.

Documents Reviewed:
Yuma Contract Amendment 7/1/06
Tucson Contract Amendment 7/1/06
Flagstaff Contract Amendment 7/1/06
Phoenix Contract Amendment 7/1/06
Terms & Conditions 9, 10

Comments:
(CYE06 OFR DA3)
None

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delegated Agreements

Standard:
DA4
The contracts/written agreements for delegated functions contain the required Minimum Subcontract Provisions, per AHCCCS requirements. (CYE 06 Contract No. YH03-0032, Section D, Paragraph 39, Attachment A)

Findings: FULL COMPLIANCE
The contract/written agreement contains the Minimum Subcontract Provisions.

Documents Reviewed:
Yuma Contract Amendment 7/1/06
Tucson Contract Amendment 7/1/06
Flagstaff Contract Amendment 7/1/06
Phoenix Contract Amendment 7/1/06

Comments:
(CYE06 OFR DA4)
None

Recommendations:
None

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delegated Agreements

Standard:
DA5
The Contractor has evidence that it monitors the delegated entity's performance on an on-going basis and subjects it to formal review according to a periodic schedule.
[42 CFR 438.230 (a), (b)(3); CYE 06 Contract No. YH03-0032, Section D, Paragraph 39]

Findings: NON COMPLIANCE
The Contractor does not show evidence of evaluating and monitoring the delegated entities performance on a regular basis and subjects the delegated entity to a formal review according to a periodic schedule maintains formal review.

Documents Reviewed:
Schedule for 2007 Administrative Reviews (tentative)
Schedule for MM/UM Site Visits
MM/UM Site Visit Tools
QM Medical Records Monitoring Tool and Outcomes Summary
Grievance Log Desk Audit Tool for CRS non-QOC Grievance Process Review
CRSA Appeal Case File Review Tool
Claims Dispute Case File Review Tool
Technical Assistance Documents
Grievance/Appeals/Claims Dispute Training Materials

Comments:
(CYE06 OFR DA5)
The Contractors has developed a tentative scheduled for the Administrative Reviews of its clinics. However, the reviews have not yet been completed. The contractor has started quarterly site reviews in November. The Contractor was unable to consistently demonstrate implementation and oversight of corrective action plan by the clinics when deficiencies are identified.

Delegated Agreements

Recommendations:
The Contractor must evaluate and monitor the delegated entities performance on a regular basis and subject the delegated entity to a formal review according to a periodic schedule.

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delegated Agreements

Standard:
DA6
The Contractor has evidence that it requires corrective action from the delegated entity when deficiencies or areas for improvement are identified.
[(42 CFR 438.230 (b)(4); CYE 06 Contract No. YH03-0032, Section D, Paragraph 39]

Findings: NON COMPLIANCE
The Contractor does not show evidence that it requires corrective action from a delegated entity when areas of deficiency or improvement are identified.

Documents Reviewed:
Flagstaff/Tucson/Phoenix/Yuma
Notice to Cure Letter
Credentialing Site Review CAP Request Letter
Email Notification extending Credentialing CAP due date
Letter on Performance Measures
Letter of acceptance of 2006 Administrative Review and Cleft Lip/Cleft Palate CAPs
2006 Administrative Review and Cleft Lift/Cleft Palate CAPs
Letter asking for corrections of Claims reports

Comments:
(CYE06 OFR DA6)
The Contractor has made significant improvements in this area within the past 6 months. However, the Contractor is unable to demonstrate it validates the implementation of CAPs to ensure the deficiencies have been corrected.

Recommendations:
The Contractor must show evidence that it requires corrective action from a delegated entity when areas of deficiency or improvement are identified.

ADHS/CRSA
AHCCCS OFR Standards
CYE 2007

Delegated Agreements

Standard:
DA7
The Contractor receives periodic reports from the delegated entity. (List reports and frequency of reporting.)
[(42 CFR 438.230 (b)(2)(i); CYE 06 Contract No. YH03-0032, Section D, Paragraph 39]

Findings: FULL COMPLIANCE
The Contractor shows evidence that it receives periodic reports from the delegated entities.

Documents Reviewed:
CRSA Contracting Reporting

Comments:
(CYE06 OFR DA7)
None

Recommendations:
None